FREE GUIDE · FOR PRACTICE ADMINISTRATORS AND SURGEONS HIRING

The Ortho PA Hiring Guide (California, 2026)

For practice administrators and orthopaedic surgeons hiring physician assistants in California. Current as of September 22, 2026.

> **Disclaimer:** This guide is educational and is not legal or billing advice. Verify anything you act on with your healthcare counsel and certified coders.

Hiring an orthopaedic PA in California involves more than finding a good candidate. The rules changed on January 1, 2026, out-of-state licensing takes months, and a 1099 contract for a PA is hard to defend under AB 5. This guide covers what the law allows, how to classify the role, how long each step takes, what to pay, and how to run the first 90 days. Every number and legal statement is footnoted to a primary source listed at the end.

1. What California law allows in 2026

The practice agreement is the governing document

California replaced the old "delegation of services agreement" (DSA) with a **practice agreement**, effective January 1, 2020 (SB 697, Stats. 2019, Ch. 707).[1,2] The statute defines it as the writing, developed collaboratively by one or more physicians and one or more PAs, that defines the medical services the PA may provide.[2] A DSA in effect before January 1, 2020 still counts as a valid practice agreement.[3] If yours dates from before 2020, it may still reflect the old ratio or say nothing about first assist, so it's worth a fresh read.

A practice agreement must cover:[3]

- [ ] The types of medical services the PA is authorized to perform
- [ ] Policies and procedures to ensure adequate supervision

- [ ] How the PA's competency will be evaluated
- [ ] Drug and device furnishing
- [ ] Any other terms the parties agree to

It must be **signed** by the PA and one or more physicians,[3] and **dated** by the PA and one or more authorized physicians.[4] The PA Board does not approve practice agreements,[3] and it has said it will not publish a sample template.[1] You write your own, which means you can tailor it to an ortho practice.

Ortho-specific items to write in deliberately:

- **First and second assist.** A PA may perform surgical procedures and act as first or second assistant in surgery *as authorized by the practice agreement*.[5] If the agreement doesn't authorize it, the PA shouldn't be doing it.
- **Schedule II diagnoses.** If the PA will furnish Schedule II drugs (post-op opioids, for example), the agreement must name the diagnoses, illnesses, injuries or conditions for which they may do so.[6] Writing these by procedure type is a practical approach.
- **Chart review policy.** See "Co-signature is optional" below.
- **Competency evaluation.** Required anyway.[3] For a new surgical PA, this is where you describe how first-assist skills get checked and signed off.

Ratio: one physician may now supervise eight PAs

Since January 1, 2026, a physician may supervise up to **eight** PAs at any one time (AB 1501, Stats. 2025, Ch. 194).[7] The prior limit was four.[8] The Board's 2020 SB 697 FAQ still says four, so don't rely on it for the ratio.[1] The statute carves out an exception under BPC 3502.5, which covers declared emergencies.[7]

Supervision does not mean physical presence

Supervision does not require the physician to be physically present. It does require the physician to be available by telephone or other electronic communication at the time the PA examines the patient.[2] The supervising physician remains responsible for all medical services the PA provides under their supervision.[9]

Competence sets the real limit on scope. The PA must be competent to perform the services, with education, training and experience that prepared them to do so.[10] If a task exceeds the PA's competence, they must consult a supervising physician or refer the patient.[4]

Chart co-signature is optional

California no longer requires a physician to review or countersign a PA's medical records **unless the practice agreement requires it**.[10,1] The law also dropped the requirement that each episode of care identify the supervising physician.[1]

Two cautions before you drop co-signature entirely:

1. **Billing rules are separate from practice law.** For Medicare split/shared visits, AAPA lists a requirement that the physician sign and date the medical record.[11] Hospital bylaws and payers may add their own rules.
2. **Co-signing does not change who billed the service.** Having a physician review or co-sign a PA's chart does not allow the PA's service to be billed under the physician's name.[11]

Decide what you want (for example, co-sign for the first 60 days, then a sample audit), and write that into the practice agreement.

Hospital work needs a supervisor with privileges there

A PA working in a general acute care hospital must be supervised by a physician **with privileges to practice in that hospital**.[10] If your PA will round, take call or first-assist at three hospitals, map which of your surgeons holds privileges at each one before you set the schedule.

Controlled substances

- A PA may furnish or order Schedule II through V drugs as set out in the practice agreement. Schedule II and III may also be furnished under a patient-specific order approved by the treating or supervising physician.[6]
- The PA must complete a pharmacology course before furnishing any drug. A DEA-registered PA must also complete a continuing-education course covering Schedule II drugs and addiction risk.[6] The Board says a licensed PA who hasn't taken that course must finish it before renewing their license.[1]
- Protocols and formularies for controlled substances are not required.[1]
- A PA's drug order counts as a prescription, and the PA's signature is a prescriber's signature.[6] PA prescription pads no longer need to list the supervising physician.[1]
- Federally, PAs register with the DEA as "mid-level practitioners."[12]
- Once the PA receives a DEA registration, they must apply for access to CURES, California's prescription monitoring database.[13]

- Before prescribing a Schedule II, III or IV drug to a patient for the first time, the prescriber must check CURES, and must check again at least every six months while the prescription continues. A nonrefillable supply of seven days or less given as part of treatment for a surgical procedure is exempt, but only when furnished in a listed setting, which includes the office of a health care practitioner.[14]

Workers' compensation

Many ortho practices see a steady flow of workers' comp patients. PAs may treat these patients, but the supervising physician is deemed the treating physician.[15] Under a protocol, the PA may authorize time off work for up to three calendar days, and may co-sign the Doctor's First Report, but the treating physician makes any temporary disability determination and signs the report.[15] The statute still uses pre-2020 "standardized procedures or protocols" language, so confirm with counsel how it fits your practice agreement.

2. W-2 or 1099? AB 5 and your PAs

Short answer: plan on W-2, and have employment counsel review any other structure.

- **The default is employee.** Under Labor Code 2775, a person paid for labor or services is an employee unless the hiring entity proves all three prongs of the ABC test.[16]
- **PAs are not exempt.** Labor Code 2783(b) exempts licensed physicians, dentists, podiatrists, psychologists and veterinarians providing services to or by a health care entity.[17] Physician assistants are not on that list, so they stay under the ABC test.
- **Prong B is where a PA contract usually fails.** The state's guidance says contracted workers who serve in a role comparable to existing employees "will likely be viewed as working in the usual course of the hiring entity's business."[18] A PA seeing your patients alongside your employed PAs fits that description.
- **The business-to-business exemption is narrow.** Labor Code 2776 sets a list of conditions. One is that the provider serves the contracting business "rather than to customers of the contracting business."[19] A PA seeing your patients is arguably serving your customers. That is our reading, not legal advice.

The structures that avoid the problem are:

1. **A W-2 employee of the practice**, including part-time or per-diem W-2.
2. **A W-2 employee of a staffing or locum agency** that bills the practice.

Medicare accepts any of these. It recognizes PAs as W-2 employees, leased employees or independent contractors, and has allowed direct payment to PAs since January 1, 2022.[11,20] State employment law still decides classification. One billing wrinkle: for incident-to billing, the

PA must be a direct financial expense to the billing physician (W-2, leased employee or independent contractor) or share the same employer tax ID.[11]

Have employment counsel review your structure before you sign.

3. Realistic timelines for out-of-state hires

California has the second-most board-certified PAs of any state (15,898), but ranks 45th in PAs per 100,000 residents (40.4).[21] The local pool is thin for the population, so many ortho searches end up recruiting from other states. Here is what that involves.

No shortcuts

- **No compact.** California is not a member of the PA Licensure Compact. An out-of-state PA needs a full California license.[22]
- **No general temporary license.** Expedited temporary licensure is limited to spouses and partners of active-duty military assigned to a California duty station.[23] Expedited *review* (not a temporary license) is available to honorably discharged veterans, refugees, asylees and SIV holders, applicants intending to provide abortion services, and DoD SkillBridge participants.[24]

What the candidate must submit[24]

- [ ] **PANCE score release** from NCCPA. Letters verifying certification or PANRE don't meet the requirement.
- [ ] **License verifications sent directly** by every state or agency that ever licensed them. The Board won't accept verifications the applicant submits. Start these on day one, since you don't control how fast other states respond.
- [ ] **NPDB self-query report**
- [ ] **Criminal history check** (fingerprints, below)
- [ ] **Fees:** $60 application processing, $250 initial license, and $49 fingerprint card processing if using ink cards

How long each step takes

Step	What the source says
Live Scan fingerprints	Must be done in California. Results reach the Board within 1 to 3 business days.[24]

Step	What the source says
Ink fingerprint cards (out of state)	Results typically reach the Board in 2 to 4 weeks. A rejected card can add another 2 to 4 weeks.[24]
Board initial review	Target is 30 days from payment.[24] On September 11, 2026, the Board was working on online initial applications received August 7, 2026, a queue of about 35 days before first review.[25]
License issuance	Weekly. Applications with deficiencies are delayed.[25]
Hospital credentialing and privileges	One published study found 103 days for traditional credentialing (36 days with a faster proxy method).[26] That was telehealth credentialing in South Carolina, not California ortho, so treat it as a rough reference. Ask each hospital's medical staff office for their current timeline.
Payer enrollment (Medicare, Medi-Cal, commercial)	We found no reliable published figure. Plan for several months and ask each plan.

Practical moves that save time:

- If the candidate can visit California, have them do **Live Scan** during the visit instead of mailing ink cards.[24]
- Send the license-verification requests the week the offer is signed.
- Open the hospital privileging file as early as each medical staff office allows.
- Remember the supervising surgeon must hold privileges at each hospital where the PA works.[10]

Certification after hire

California license renewal requires 50 hours of approved CME every two years, **or** current NCCPA certification at renewal.[27] So California itself doesn't require ongoing NCCPA certification. Keeping NCCPA certification means 100 CME credits every two years and passing PANRE or PANRE-LA by the end of the tenth year.[28] Medicare's PA qualifications include passing the NCCPA exam,[20] and hospital bylaws may require current certification. Check each hospital's bylaws.

4. What California PAs are paid

Use government data as your anchor, then adjust for ortho, call and surgical skill.

California, all PAs (BLS, May 2025)[29]

Measure	Value
Employment	13,600
Annual mean	$169,110
Annual median	$165,650
10th percentile	$99,380
25th percentile	$136,730
75th percentile	$206,990
90th percentile	$225,190
Hourly median	$79.64

California metro medians (BLS, May 2025)[30]

Metro	Median
San Jose	$223,640
San Francisco-Oakland	$184,380
Riverside-San Bernardino	$165,490
San Diego	$165,160
Los Angeles-Long Beach-Anaheim	$161,890
Sacramento	$161,470
Fresno	$155,440

National comparisons

- The U.S. median for PAs was $135,880 (mean $141,280, 162,150 employed).[31] The California median is about 22% higher (our calculation: $165,650 ÷ $135,880).

- Orthopaedic PAs nationally (NCCPA, 2025 data): mean income $139,968 and median $135,000 across all PA positions, up from $123,934 and $115,000 in 2021.[32] Among ortho PAs working 40+ hours a week, mean income was $134,571 for women and $152,258 for men.[32] Check your own offers for the same gap.
- AAPA reports a national PA median of $140,000 for 2025. Nearly 58% of full-time PAs received a bonus, with a median of $6,000.[33]

What we don't have: a verified California-specific ortho PA pay figure. The NCCPA ortho numbers are national, and AAPA's specialty and state breakdowns are behind a paywall. Benchmarks vary; ask us for current market data.

For context on demand, BLS projects PA employment to grow 21% from 2025 to 2035, with about 11,500 openings a year nationally.[31]

5. Writing the job post

Candidates read a PA post looking for the facts that decide whether the job is livable. Give them those facts up front.

Include:

- [ ] **The actual split of the week.** Clinic days, OR days, and how many hours of each. "Ortho PA" can mean nearly all clinic or nearly all OR.
- [ ] **Subspecialty and case mix.** Joints, sports, spine, hand, trauma. Name the common cases.
- [ ] **First assist, stated plainly.** Whether it's expected, how much, and whether you'll train it.
- [ ] **Call.** Frequency, whether it's phone or in-house, and how it's paid. "Compensation for services performed outside normal duties" is a named source of APP dissatisfaction.[34]
- [ ] **Hospitals.** Which ones, since each needs its own privileges.
- [ ] **Pay range and bonus structure.** Anchor to the BLS figures above for your metro.
- [ ] **Licensing.** Whether you require an active California license or will support an out-of-state candidate through licensing, and the realistic start date if so.
- [ ] **Onboarding and mentorship.** Say who they'll learn from and for how long. Structured mentorship is linked to better retention (see Section 7).
- [ ] **CME time and dollars.**
- [ ] **Patient load.** Nationally, ortho PAs working 40+ hours see a mean of 68 and median of 60 patients a week.[32] If yours is far above that, say so and explain the support.

A skeleton you can adapt:

> **Orthopaedic PA, Sports and Joints, [City]** Three surgeons, two current PAs. Your week: 3 clinic days ([number] patients a day: post-ops, new injuries, injections) and 2 OR days as first assist on arthroscopy and joint replacement at [Hospital A] and [ASC B]. Call: 1 weekend in 6, phone call with occasional ED consults, paid at [rate]. Pay: [range] plus [bonus structure]. California license required, or we'll support your application and plan a [month] start. You'll be paired with [Dr. X] for your first 90 days, with a set review at 30, 60 and 90 days.

6. Interviewing for OR first assist and trauma call

A résumé that says "first assist" can mean anything from holding retractors to closing independently. Find out which.

First assist

Ask for specifics:

- "Walk me through your role on your last total knee, from positioning to dressing."
- "Which cases have you closed on your own? Which have you not?"
- "How many of [your common cases] did you assist on in the last year?" Ask for a case log if they keep one.
- "Which implant systems and arthroscopy towers have you used?"

Verify:

- Call a surgeon they assisted, not only a manager. Ask: "Would you let them close without you in the room?" and "What would you want them to work on?"
- Plan a proctored period. The practice agreement must describe how competency is evaluated,[3] so write the first-assist sign-off process there.
- Listen for honest limits. The law requires a PA to consult or refer when a task exceeds their competence.[4] A candidate who can name what they're not ready for is easier to supervise safely.

Trauma and call

- "Describe a night on call where you had to decide whether to wake the surgeon. What did you decide?"
- "What reductions and splints are you comfortable doing without the surgeon present?"

- "What call schedule have you worked, and what would make call sustainable for you?"

Confirm logistics before the offer: which hospitals, which supervising surgeons hold privileges at each,[10] and response-time expectations. Nationally, 26.9% of ortho PAs report one or more burnout symptoms,[32] so call load is worth an honest conversation during the interview.

7. First 90 days: onboarding checklist

New PAs and NPs, interviewed about what good onboarding looks like, named these elements: building competence, EHR training, mentorship, orientation to how the organization works, a tailored ramp-up of the patient schedule, and clear expectations.[35] (That study was in primary care, but the list transfers.)

It pays off. In one program, structured mentorship raised first-year retention of new PAs and NPs from 85% to 96%, and second-year retention from 65% to 83%.[36] In a pediatric academic system, APP fellows reached productivity 4.2 months sooner than non-fellow hires, and turnover fell from 8.2% to 3.8%.[37]

Before day one

- [ ] California license issued
- [ ] Practice agreement signed and dated by the PA and supervising physician(s),[3,4] including first-assist authorization[5] and Schedule II diagnoses[6]
- [ ] DEA registration in process; CURES application submitted once DEA registration arrives[13]
- [ ] Pharmacology course and, if DEA-registered, Schedule II course completed[6]
- [ ] Hospital privileges in process at each facility, with a privileged supervising surgeon mapped to each[10]
- [ ] Payer enrollment started (Medicare, Medi-Cal, commercial)
- [ ] EHR, PACS and scheduling accounts requested
- [ ] Mentor assigned (a named surgeon, ideally with an experienced PA as a second contact)

Days 1 to 30: learn the system

- [ ] EHR training with templates and order sets for your common visits
- [ ] Shadow each surgeon in clinic and in the OR
- [ ] Walk through your workers' comp workflow, including who signs what[15]
- [ ] Walk through post-op opioid prescribing and CURES checks[14]
- [ ] Reduced schedule: post-ops and simple follow-ups first

- [ ] Weekly check-in with the mentor
- [ ] Written 30/60/90-day expectations, agreed with the PA

Days 31 to 60: build the schedule

- [ ] Add new-problem visits and injections as competence is shown
- [ ] First-assist cases with the proctoring surgeon, graded sign-off by case type
- [ ] Review chart-review or co-signature policy against what you wrote in the practice agreement[10]
- [ ] Start tracking global-period post-op visits separately (for example with CPT 99024), since that work is otherwise hidden in the surgeon's global package[38]
- [ ] 60-day review: what's working, what support is missing

Days 61 to 90: settle in

- [ ] Full or near-full template
- [ ] Join the call schedule, starting with backup shifts
- [ ] Documented competency review, as your practice agreement requires[3]
- [ ] 90-day review: pay, call, schedule and goals for year one
- [ ] Mentor meetings continue, moving to monthly

8. Locum and temporary coverage

When a locum makes sense

- **Leave coverage.** Parental, medical or extended leave where you know the end date.
- **Bridging a permanent hire.** Your new PA has a start date three months out and your surgeons are losing clinic slots now.
- **Testing a new service line or a new surgeon's ramp-up** before committing to a permanent role.

A catch with out-of-state locums: the licensing rules above apply in full. There's no compact and no general temporary license.[22,23] A locum from another state can't start any sooner than a permanent hire from that state. For short-notice coverage, look for PAs who already hold an active California license.

How to structure a 3 to 6 month contract

Given AB 5, the two defensible structures are the same as for a permanent hire:[16,17,18]

1. **Practice W-2.** A fixed-term, part-time or per-diem W-2 employee of the practice.
2. **Agency W-2.** The PA is a W-2 employee of a staffing or locum agency that bills your practice.

Paying the PA directly on a 1099 is the structure most likely to fail the ABC test. **Have employment counsel review the arrangement.**

Contract checklist:

- [ ] Start date contingent on an active California license and hospital privileges
- [ ] Defined end date and any extension terms
- [ ] Practice agreement signed and dated for the locum PA, with first-assist and Schedule II terms if they apply[3,5,6]
- [ ] Named supervising surgeon with privileges at each hospital the PA will work in[10]
- [ ] Schedule: clinic days, OR days, call
- [ ] Who carries malpractice coverage, including tail
- [ ] How the PA's services will be billed and under whose enrollment (confirm with your billing team)
- [ ] Notice period for either side
- [ ] EHR access set up before day one, since a short contract can't absorb a slow start

Housing and stipends

We didn't find a reliable published source for California locum PA pay rates or housing and travel stipend norms, so we aren't printing numbers here. Benchmarks vary; ask us for current market data.

A note from FirstAssistPA

This guide is from FirstAssistPA, a small placement service focused on orthopaedic PAs in California, founded by Anthony Adams. If you'd like help filling a role, your first placement is free. If you aren't happy with a PA we place, for any reason, we'll replace them at no charge.

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