FREE COLORADO GUIDE · FOR DENVER AND MOUNTAIN-TOWN PRACTICES HIRING

The Ortho PA Hiring Guide (Colorado, 2026)

For practice administrators and orthopaedic surgeons hiring physician assistants in Denver, the Front Range and Colorado's mountain towns. Current as of September 24, 2026.

By Anthony David Adams · Published September 24, 2026

IN SHORT

Since August 7, 2023, Colorado PAs work under a collaborative agreement instead of physician supervision, but the agreement stays supervisory until the PA has 5,000 practice hours, or 3,000 hours in a new practice area. Colorado has joined the PA Licensure Compact, but privileges aren't projected before early 2027, so an out-of-state hire still needs a full Colorado license, and Colorado presumes a paid PA is an employee. The BLS median for Colorado PAs was $134,540 in May 2025.

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

Colorado rewrote the PA rules in 2023. PAs no longer work under "supervision"; they work under a collaborative agreement, and how much oversight that agreement needs depends on how many hours the PA has practiced, and how many in your specialty. Colorado has also joined the PA Licensure Compact, but the compact isn't issuing privileges yet, so an out-of-state hire still needs a full Colorado license. And Colorado presumes a PA working in your clinic is an employee. This guide covers what the law allows, how to classify the role, how

long each step takes, what to pay, how to run the first 90 days, and what changes for seasonal ski-trauma coverage. Every number and legal statement is footnoted to a primary source listed at the end.

1. What Colorado law allows in 2026

The collaborative agreement is the governing document

Since August 7, 2023 (SB23-083), a Colorado PA must have a **collaborative agreement** with a physician or physician group instead of a supervising physician.[1,2] A PA may not provide care without one.[3] The statute defines it as a written agreement describing how the PA collaborates with a physician or physician group, and defines "collaboration" as consultation with, or referral to, a physician.[4]

Every collaborative agreement must include:[4]

- [ ] The PA's name, license number and primary location of practice
- [ ] Signatures of the PA and the physician or physician group
- [ ] A description of the PA's process for collaboration, scaled to the PA's location and area of practice. It may include decisions made by the physician or group and the credentialing or privileging requirements of the PA's primary practice location.
- [ ] A description of the performance evaluation process, which the employer may run
- [ ] Any additional requirements the physician sets, such as extra oversight, limits on autonomous judgment, and a named primary contact for collaboration

The agreement is kept on file at the PA's primary practice location and shown to the Board on request.[3] Nothing is filed with the Board: the primary supervisor registration form and supervising physician forms are no longer required.[2]

Two conditions on the physician side:

- The collaborating physician must be **actively practicing in Colorado with a regular and reliable physical presence** in the state.[4] Practicing mainly by telehealth doesn't count.[5] A surgeon who has moved away, or who covers your clinic only by video, can't be the collaborating physician.
- **An employer can't make collaboration a condition of a physician's employment.**[3] Confirm which surgeon is willing to sign before you make the offer.

Ortho-specific items to write in deliberately:

- **First and second assist.** We found no mention of first assist in Colorado's PA statute or Rule 1.15. The PA may perform acts within their education, experience and competency,[3] and hospitals authorize what PAs do on their premises (see below).[6] Put your first-assist expectations, and how they get signed off, in the agreement's "additional requirements."
- **Hospital and ASC requirements.** The collaboration process may incorporate the credentialing or privileging requirements of the PA's primary practice location.[4] Reference each facility's rules rather than restating them.
- **Limits and primary contact.** The agreement may set limits on autonomous judgment and name a primary contact.[4] For a new ortho PA, this is where you say which cases they take to a surgeon before acting.
- **Evaluation process.** Required in every agreement.[4] Describe how first-assist and procedure skills get checked.

Newer PAs and specialty changers work under a "supervisory agreement"

The oversight level depends on hours, not years:[4,5]

The PA has...	Agreement type
5,000 or more practice hours, and is staying in the same practice area	Collaborative agreement (the five items above)
Fewer than 5,000 practice hours	Supervisory agreement
Fewer than 3,000 practice hours in a *new* practice area	Supervisory agreement
An emergency department job at a Level I or II trauma center	Supervisory agreement, indefinitely

5,000 hours is about 2.4 years of full-time work (our calculation: 5,000 ÷ 2,080 hours a year). Once the PA reaches the required hours, the extra supervisory requirements no longer apply.[4]

A supervisory agreement adds three things:[4]

1. Collaboration during the **first 160 practice hours**, in person or through technology, as the physician or group permits.
2. Written elements on the expected nature of collaboration: the PA's expected area of practice, what support and consultation to expect, and how you'll communicate.
3. A **performance evaluation, discussed with the PA, after 6 months with the employer and again after 12 months**, then as the physician or group decides. The employer may run it, but not less often than that.

The specialty-changer rule matters for ortho. A PA with years in emergency medicine or primary care but little orthopaedic time may fall under the 3,000-hour rule. Neither the statute nor Rule 1.15 defines "practice area,"[4,5] so ask counsel how it applies to your candidate. PAs with prior out-of-state practice, or licensed in Colorado before August 7, 2023, can document their hours to the Board with a signed affidavit.[4]

Because the evaluation clock runs from time "with the employer," it starts over when a PA under 5,000 hours changes jobs. That's our reading of the text.[4]

Ratio: 1:8 applies only to supervisory agreements

A physician may not hold supervisory agreements with more than **eight** individual PAs.[5] We found no numeric cap in the current statute for ordinary collaborative agreements. The pre-2023 statute let a physician supervise up to eight PAs, and that language is no longer in the 2024 statute.[7,3] Our reading is that experienced PAs aren't subject to a ratio. Have counsel confirm before you build a staffing model on it.

Under a supervisory agreement, the physician must personally direct and supervise (not through intermediaries) and, when not on site, be readily available by phone or other telecommunication device.[5]

Performance evaluations apply to every PA

Every collaborating physician or group must develop and carry out a periodic performance evaluation.[5] It must cover domains of competency relevant to the practice, use more than one assessment method, and consider the PA's education, training, experience and specialty knowledge.[4] Rule 1.15 lists possible domains, including "procedural and technical skills appropriate to the practice," and possible methods: co-management, direct observation, chart review with the charts identified, and feedback from patients and other providers.[5]

Keep the records. The physician or group must maintain documentation of each evaluation, and the Board may audit them.[5]

Chart co-signature: none required that we found

We found no requirement in the statute or Rule 1.15 that a physician co-sign or review a set share of a PA's charts.[3,4,5] Chart review appears only as one optional way to evaluate performance.[5] What the rule does require is that the PA write a chart note for every patient, and when they consult a physician about a patient, record that physician's name and the date.[5]

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.[8] 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.[8]

Decide what you want (for example, co-sign for the first 60 days, then a sample audit) and write it into the agreement as an additional requirement.

Hospital work needs the hospital's authorization

A PA may not practice in a licensed hospital without authorization from the hospital's governing board, which may grant, deny or limit it under its own procedures.[6] Unlike California, Colorado's statute doesn't say the collaborating physician must hold privileges at that hospital (our reading).[6,4] Each hospital's bylaws may say more, so ask each medical staff office.

Emergency-department work is the exception to watch. A PA working in the ED of a Level I or II trauma center stays under a supervisory agreement indefinitely.[4] That rule is about the ED. It doesn't by its terms reach clinic, OR or consult work.

Liability, insurance and ownership

- **The PA is liable for the care they provide.**[3]
- **Malpractice coverage:** PAs must carry at least $1 million per incident and $3 million annual aggregate, or meet an alternative. A PA covered by an employer's or contracting agency's policy at those amounts is exempt from carrying their own.[9]
- **Ownership:** a PA may not own a majority of a medical practice.[3]
- **Identification:** the PA must identify as a PA visually and verbally, and the employer or physician must tell patients the PA is a PA.[3,5]

Controlled substances

- With a collaborative agreement, a PA may prescribe and dispense medication, including controlled substances.[3]
- A PA can't prescribe any controlled substance without a DEA registration.[5] Federally, PAs register as "mid-level practitioners."[10]
- PA prescriptions must show the PA's name and the facility's name and address (plus the specialty clinic, in a multispecialty organization).[3] The collaborating physician's name isn't required.

- Schedule II to IV prescriptions must be sent electronically, with listed exceptions.[11]
- Every DEA-registered prescriber must register with Colorado's Prescription Drug Monitoring Program (PDMP).[12]
- **Check the PDMP before every opioid prescription.** The post-surgical exemption only covers pain expected to last more than 14 days. Other exemptions include opioids given in a hospital and a single dose for a single test or procedure.[13] Colorado has no exemption for a short post-op supply written in the office. A designee in the practice may run the query.[13]
- **First-time opioid limit:** no more than a 7-day supply to a patient who hasn't had an opioid prescription from that prescriber in the last 12 months, with an optional second 7-day fill. Post-surgical pain expected to last more than 14 days is an exception. The limit applies to PAs.[14]
- In 2026, SB26-138 directed regulators to require up to four hours of prescribing-related training per license cycle.[15] The Medical Board has proposed repealing its separate substance-use CE rule to match.[16] Check the final rule before renewal.

Workers' compensation

Many ortho practices see a steady flow of workers' comp patients. A PA may earn Level I accreditation, but services that require Level I accreditation must be delegated to the PA by a Level I accredited physician.[17] Only a physician may determine that a claimant has reached maximum medical improvement or has no permanent impairment.[17] Build both into your workflow.

2. W-2 or 1099? Colorado's presumption of employment

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

- **The default is employee.** Colorado treats paid services as employment unless it's shown that the worker is free from control and direction, both on paper and in fact, *and* customarily engaged in an independent business related to the work.[18,19] Workers' compensation uses the same test.[20]
- **Control that the law itself requires doesn't count against you.** Control exercised because a state or federal statute or regulation requires it is not considered.[18] Our reading is that the oversight Colorado's collaboration law requires wouldn't by itself make a PA an employee. The control a practice adds on its own (set clinic days, your templates and EHR, productivity targets) would count. That is an interpretation, not legal advice.

- **A written contract can shift the burden, but the factors are hard to meet with a PA.** The document must show that the practice doesn't, among other things, set a quality standard, pay a salary or hourly rate instead of a fixed or contract rate, dictate when the work is done, provide more than minimal training, or pay the individual personally instead of their business. It also needs a prominent disclosure that the contractor gets no unemployment benefits and owes their own taxes.[18] Even then, CDLE says a qualifying contract doesn't mean the worker will ultimately be found to be a contractor.[19]
- **Penalties.** A misclassification finding means back premiums and interest. Willful misclassification can bring fines of up to $5,000 per worker the first time and up to $25,000 per worker after that.[21]
- **You can ask first.** CDLE gives written advisory opinions on worker classification on request.[22]

The structures that avoid the problem are:

1. **A W-2 employee of the practice**, including part-time, per-diem or fixed-term 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.[8,23] 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.[8]

Have employment counsel review your structure before you sign.

3. Realistic timelines for out-of-state hires

Colorado has 5,434 board-certified PAs, or 90.4 per 100,000 residents, which ranks sixth in NCCPA's state table.[24] That's a deeper local pool than most states have. Even so, a specialty search, especially for a mountain town, often ends up recruiting from other states. Here is what that involves.

The compact isn't live yet

Colorado joined the PA Licensure Compact through SB24-018, effective August 7, 2024.[25] As of the compact's August 28, 2026 newsletter, no state was issuing compact privileges yet, and the projection for the first privileges is early 2027.[25] Until then, an out-of-state PA needs a full Colorado license. When privileges do start, eligibility will require an active, unencumbered license from a compact state and current NCCPA certification, among other things.[25]

What the candidate must submit[26,27]

- [ ] Proof of graduation from an accredited PA program, and **NCCPA exam** results
- [ ] **FSMB disciplinary report**, requested by the PA and sent electronically to the Board (FSMB charges no fee)
- [ ] **Verification of every license ever held.** Colorado accepts a screen capture from the other state's website if it shows the original issue date and any discipline.
- [ ] **NPDB report**, dated within four months of the application, if they've held a license before
- [ ] **Practice history** for the last two years
- [ ] **Fingerprints** through one of Colorado's two approved vendors; see below
- [ ] The application fee. DPO doesn't print the amount on its PA pages, and fees can change each July 1.[26]

How long each step takes

Step	What the source says
Fingerprint background check (CBI and FBI)	Electronic prints through IdentoGO or American Bioidentity; non-resident instructions exist. DPO needs both results before it issues a license. Don't submit prints until the application is ready.[28] We found no published turnaround time.
Board review	We found no published PA processing time or queue. Ask DPO when you apply.
License renewal timing	All PA licenses expire January 31 of even-numbered years. DPO suggests applicants near the renewal period consider holding their application until just after it, to avoid paying application and renewal fees back to back.[26] The next expiry is January 31, 2028 (our calculation).
Hospital credentialing and authorization	One published study found 103 days for traditional credentialing (36 days with a faster proxy method).[29] That was telehealth credentialing in South Carolina, not Colorado ortho, so treat it as a rough reference. Ask each hospital's medical staff office for their current timeline.
Payer enrollment (Medicare, Health First Colorado, commercial)	We found no reliable published figure. Plan for several months and ask each plan.

Practical moves that save time:

- Line up the collaborating surgeon, and decide whether the PA needs a supervisory agreement, before the offer.

- Have the candidate order the FSMB report and NPDB report the week the offer is signed.
- If the candidate has fewer than 5,000 hours in Colorado but more elsewhere, have them prepare the practice-hours affidavit.[4]
- Open the hospital authorization file as early as each medical staff office allows.

Certification after hire

We didn't find a Colorado continuing-education hour requirement for PA license renewal. The Board's 30-hour CME rule is written for physicians.[30] Keeping NCCPA certification means 100 CME credits every two years and passing PANRE or PANRE-LA by the end of the tenth year.[31] Medicare's PA qualifications include passing the NCCPA exam,[23] the PA Compact will require current certification,[25] and hospital bylaws may require it too. Check each hospital's bylaws.

4. What Colorado PAs are paid

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

Colorado, all PAs (BLS, May 2025) [32]

Measure	Value
Employment	3,270
Annual mean	$139,580
Annual median	$134,540
10th percentile	$104,590
25th percentile	$124,100
75th percentile	$156,400
90th percentile	$174,090
Hourly median	$64.68

Colorado area medians (BLS, May 2025) [33]

Area	Median
Northwest Colorado nonmetro (includes Eagle, Pitkin, Routt and Summit counties)	$144,290
Boulder	$136,540
Pueblo	$135,640
Colorado Springs	$135,200
Greeley	$134,550
Denver-Aurora-Centennial	$134,540
Fort Collins-Loveland	$134,260
Eastern and Southern Colorado nonmetro	$133,810
Southwest Colorado nonmetro	$130,670
Grand Junction	$129,930

Denver metro detail: 1,650 PAs employed; mean $141,060; 25th percentile $127,920; 75th percentile $161,790; 90th percentile $175,590.[33]

Northwest Colorado nonmetro detail: 140 PAs employed; mean $142,200; 25th percentile $132,530; 75th percentile $151,930; hourly median $69.37.[33] The area covers Eagle, Garfield, Grand, Jackson, Lake, Moffat, Pitkin, Rio Blanco, Routt and Summit counties.[34] Its median is about 7% above the statewide median (our calculation: $144,290 ÷ $134,540), but it rests on about 140 PAs, so treat it as directional.

National comparisons

- The U.S. median for PAs was $135,880 (mean $141,280).[35] The Colorado median is about 1% lower (our calculation: $134,540 ÷ $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.[36] Among ortho PAs working 40+ hours a week, mean income was $134,571 for women and $152,258 for men.[36] 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.[37]

What we don't have: a verified Colorado-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.[35]

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.[38]
- [ ] **Hospitals and ASCs.** Which ones. Each hospital must authorize the PA's practice there.[6]
- [ ] **Experience level.** Whether you'll take a PA under 5,000 hours, or one new to ortho, and how the first 160 hours of collaboration will work if so.[4]
- [ ] **Pay range and bonus structure.** Anchor to the BLS figures above for your area.
- [ ] **Licensing.** Whether you require an active Colorado 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.[36] 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]. Colorado license required, or we'll support your application and plan a [month] start. New grads and PAs new to ortho welcome: [Dr. X] will be your collaborating surgeon, with the first 160 hours side by side and set reviews at 30, 60 and 90 days, then 6 and 12 months.

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.

Hours first

- "About how many total practice hours do you have? How many in orthopaedics?" The answers decide whether you need a supervisory agreement.[4]
- "Can you document hours from other states?" Out-of-state practice can be credited by affidavit.[4]

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. Every collaborative agreement must describe the performance evaluation process, and procedural skills are one of the listed domains,[4,5] so write the first-assist sign-off process there.

- Listen for honest limits. Colorado limits a PA to acts within their education, experience and competency, and requires them to collaborate as the patient's condition and their own competence indicate.[3] A candidate who can name what they're not ready for is easier to work with 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, whether each will authorize the PA,[6] which surgeon is the collaborating physician and primary contact,[4] and response-time expectations. Nationally, 26.9% of ortho PAs report one or more burnout symptoms,[36] 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.[39] (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%.[40] 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%.[41]

Before day one

- [ ] Colorado license issued (fingerprint results in)[28]
- [ ] Collaborative agreement signed by the PA and the physician or group, with all five required items,[4] first-assist expectations, and a named primary contact; a copy filed at the PA's primary practice location[3]
- [ ] If under 5,000 hours or new to ortho: supervisory-agreement elements written in, the 160-hour collaboration plan set, and 6- and 12-month evaluation dates on the calendar[4]
- [ ] Malpractice coverage confirmed at $1M/$3M, through your policy or the PA's[9]

- [ ] DEA registration in process; PDMP account registered once it arrives[12]; e-prescribing for controlled substances set up[11]
- [ ] Hospital authorization in process at each facility[6]
- [ ] Payer enrollment started (Medicare, Health First Colorado, 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 which services need a Level I accredited physician and who determines maximum medical improvement[17]
- [ ] Walk through post-op opioid prescribing: the PDMP check before each opioid prescription, and the 7-day first-prescription limit[13,14]
- [ ] 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 any chart-review or co-signature policy against what you wrote in the agreement
- [ ] 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[42]
- [ ] 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 performance evaluation as your agreement describes, with the records kept where the Board could audit them[5]
- [ ] 90-day review: pay, call, schedule and goals for year one

- [ ] Mentor meetings continue, moving to monthly; for a supervisory agreement, the 6-month evaluation comes next[4]

8. Locum, temporary and seasonal 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.
- **Seasonal volume.** Ski season in the mountain towns (see below).
- **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: until the compact starts issuing privileges (projected for early 2027), a locum from another state needs a full Colorado license, fingerprints included.[25,28] They can't start any sooner than a permanent hire from that state. For short-notice coverage, look for PAs who already hold an active Colorado license.

How to structure a 3 to 6 month contract

Given Colorado's presumption of employment, the two defensible structures are the same as for a permanent hire:[18,19]

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 be found misclassification. **Have employment counsel review the arrangement.**

Contract checklist:

- [ ] Start date contingent on an active Colorado license and hospital authorization
- [ ] Defined end date and any extension terms
- [ ] Collaborative (or supervisory) agreement signed for the locum PA, with a named collaborating surgeon physically practicing in Colorado[4]
- [ ] Schedule: clinic days, OR days, call
- [ ] Who carries malpractice coverage at $1M/$3M, including tail[9]

- [ ] How the PA's services will be billed and under whose enrollment (confirm with your billing team)
- [ ] Notice period for either side
- [ ] EHR and PDMP access set up before day one, since a short contract can't absorb a slow start

Seasonal ski-trauma coverage in the mountain towns

A few Colorado rules shape a winter hire in Vail, Aspen, Summit County or Steamboat:

- **Pay runs higher up there.** The BLS area that includes Eagle, Pitkin, Routt and Summit counties had a median PA wage of $144,290, the highest area median in the state, on a small sample of about 140 PAs.[33,34]
- **Your collaborating surgeon can be elsewhere in Colorado, but not out of state or telehealth-only.** The law requires a regular, reliable physical presence in Colorado; we found no rule requiring it at your clinic (our reading).[4,5] For a PA under a supervisory agreement, the first 160 hours may be in person or through technology, as the physician permits.[4]
- **The mountain hospitals are Level III trauma centers.** Vail Health, Aspen Valley, St. Anthony Summit and UCHealth Yampa Valley are all designated Level III.[43] The rule that keeps ED PAs at Level I and II trauma centers under a supervisory agreement indefinitely doesn't apply at these hospitals.[4]
- **A short season can end before the first required evaluation.** For a PA under 5,000 hours, the first required evaluation comes after six months with the employer.[4] Build your own 30- and 60-day reviews into a seasonal contract.
- **Start the license early.** Fingerprint results must be in before DPO issues a license, and we found no published PA processing time.[28] Start the file months before the season, not weeks.

We found no primary source for ski-season injury or surgery volumes in Colorado, so we aren't printing numbers.

Housing and stipends

We didn't find a reliable published source for Colorado locum PA pay rates, seasonal premiums, 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 (firstassistpa.com), a small placement service focused on orthopaedic PAs, founded by Anthony David Adams. If you'd like help filling a role in Colorado, 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.

Sources

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