Return to:

eMedNY PO Box 4610

Rensselaer, NY 12144-4610

SUPERVISING PHYSICIAN CERTIFICATION

This Form Must Be Completed and Signed by Each Supervising Physician.

1.	Physician Name:		
2.	Physician License Number:		
3.	Physician National Provider Identifier (Physician Provider # (Required):	NPI) (Required):	
4.			
5.	Physician Current Service Address: _		
	_		
6.	Detail how supervision is carried out.		
CER	TIFICATION STATEMENT		
		f the Law and Regulations of the State Department on Assistant in t	
	Physician Assistant National Provider	dentifier (NPI) (Required):	_
	Physician Assistant Medicaid Provider	# (Required):	
Physi	ician Signature		
Print	Name	Date	