

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 (NPI) (Required): _____
Physician Provider # (Required): _____
4. Physician Telephone Number: _____
5. Physician Current Service Address: _____

6. Detail how supervision is carried out.

CERTIFICATION STATEMENT

In accordance with the requirements of the Law and Regulations of the State Department of Education, I have agreed to supervise Physician Assistant _____ in the manner detailed in my response to question 6.

Physician Assistant National Provider Identifier (NPI) (Required): _____

Physician Assistant Medicaid Provider # (Required): _____

Physician Signature _____

Print Name _____ Date _____