oneHealth

This form should be completed only if applicable

SUPERVISING PHYSICIAN ATTESTATION

I, _____, the undersigned, do hereby acknowledge that OneHealth defines an Extender as a Physician Assistant (PA, PAC), Advanced Practice Nurse (APN) and Certified Nurse Midwife (CNM). As an Extender I attest that I will provide professional care as reflected in the Practice Protocol/Job Description which reflects my education specialty of _____ and that these services comply with state and federal law.

I further understand that I am required to have a direct supervising physician (preceptor), who is also a Participating Provider of OneHealth, at all times. I am therefore providing the name of my current supervising physician, and their acceptance of this responsibility, below and understand that I am required to supply any changes to this information to OneHealth on an ongoing basis.

_____ _____

Extender Signature Date

Supervising Physician(s):

Name: _____

Phone: _____ Specialty: _____

Address: _____

_____

NV State License #: _____

I, _____, as the supervising physician, am a self-attested, qualifying physician, and I provide direct professional oversight and assume legal responsibility for the services provided by the advanced practice clinician, listed above, who is providing services within their scope of practice.

_____ _____

Provider Signature Date

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