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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 _____