COMMUNITY FIRST HEALTH PLANS

# SUPERVISING PHYSICIAN APPROVAL FORM

## PHYSICIAN ASSISTANT / NURSE PRACTITIONER / NURSE MIDWIFE

I_____ ☐MD ☐DO, am a participating physician with CFHP and supervising physician for _____, my specialty is _____.

He/She is a: ☐ **Physician Assistant** ☐ **Nurse Practitioner** ☐ **Nurse Midwife**

I do the hospital admissions: ☐ Yes **Name of hospital:** _____

☐ *NO

*If "No" list the name of the CFHP participating physician who will perform hospital admissions.

Name Degree Specialty

I provide 24 hour coverage: ☐ Yes ☐ * No

*If "No" list the name of the CFHP participating physician(s) who will provide 24 hour coverage

Name Degree Specialty

**Supervising Physician Signature:** _____

**Supervising Physician Printed Name:** _____

**Date:** _____

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## Prescriptive Authority Supervision

I _____, am a ☐Physician Assistant,

☐Nurse Practitioner, ☐Nurse Midwife under the above listed physician's prescriptive authority supervision

**Applicant Signature:** _____ Date: _____

**Applicant Printed Name:** _____

**Supervising Physician Signature:** _____ Date: _____

***Keeping our commitment to you***