COMMUNITY FIRST HEALTH PLANS

Supervising Physician Approval Form

Physician Assistant / Nurse Practitioner / Nurse Midwife

I _____ ☐ MD ☐ DO, am a participating physician with

Community First Health Plans and supervising physician for _____;

my specialty is _____

They are a: ☐ **Physician Assistant** ☐ **Nurse Practitioner** ☐ **Nurse Midwife**

I do the hospital admissions: ☐Yes ☐*No **Name of hospital**: _____

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

Name _____ Degree _____ Specialty _____

I provide 24 hour coverage: ☐ Yes ☐ *No

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

Name _____ Degree _____ Specialty _____

Supervising Physician Signature: _____

Supervising Physician Printed Name: _____

Date: _____

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:** _____