SKYLINE MEDICAL CENTER
APN / PA ORDERING INFORMATION

Full Name of the APN/PA: _____

Sponsoring Physician: _____

Primary Office Address: _____

_____

E-Mail Address: _____

Primary Office Phone and Fax Numbers:

Phone_____ Fax _____

APN/PA NPI Number (**required**): _____

TN License Number (**required**): _____

Is your Malpractice Policy an Individual Policy or are you covered under the Practice?

_____

YOU MUST ATTACH A COPY OF YOUR PHYSICIAN/APN/PA PROTOCOL THAT OUTLINES YOUR AGREED UPON RESPONSIBILITIES (the protocol should include what treatments/tests/services the physician has agreed to sponsor the APN/PA to perform, [example H&P's, Ordering Outpatient Laboratory and Imaging Services, Prescribing Medications, Providing Patient Education, etc.]) – YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THIS DOCUMENT.

By my signature below I acknowledge that I understand that to maintain ordering privileges at Skyline Medical Center, I must maintain a current, unrestricted Tennessee license and must not be excluded from participating in Medicare, Medicaid or Federally funded healthcare programs. I agree to notify Skyline's Medical Staff Office (769-7177) should any of the information contained on this page become inaccurate. Our Fax Number is (769-7166 or 769-7179)

Printed Name: _____

Signature: _____