SKYLINE MEDICAL CENTER
SPONSORING PHYSICIAN/NP/PA ATTESTATION STATEMENT

I _____ M.D./D.O. would like the following Advanced Practice Nurse(s)/Physician Assistant(s) who are employed and/or sponsored by me to be able to order outpatient testing (limited to labs and imaging services) at Skyline Medical Center

1) _____

2) _____

3) _____

4) _____

I understand that as their employing/sponsoring physician I am responsible for the following:

1) That I must provide Skyline's Medical Staff Office with a copy of the Sponsoring Physician/APN/PA Protocol which outlines our agreed upon treatments/tests/services prior to the APN/PA being allowed to order at Skyline and that the Protocol must include the ability to order outpatient services.

2) To be sure the APN/PA maintains at all times a current unrestricted Tennessee license, has malpractice insurance coverage under your office policy or an individual policy and that the APN/PA has his/her own NPI number which must be provided to the Medical Staff Office prior to ordering outpatient testing.

3) That the APN/PA will be immediately prohibited from ordering at Skyline should a State or Federal Sanction be taken against him/her.

4) That I must meet all State requirements for being sure the orders are medically necessary and charts are reviewed within the State required timeframe.

I understand it is my responsibility to notify Skyline's Medical Staff Office immediately should any of the following occur:

1) Should the APN/PA leave my employ, or no longer be sponsored by me.
2) Should the APN/PA have any health issue which renders them unable to perform the treatments/tests/services under our agreed upon Physician/APN/PA Protocol.
3) Should I have knowledge that a State or Federal Sanction has been taken against the APN/PA.

Printed Name: _____ Date: _____

Signature: _____