MID-LEVEL PROVIDER APPLICATION

ATTACHMENT I: STATEMENT OF AGREEMENT BY SUPERVISING PROVIDER

Name: _____ **Employed as:** _____
Mid-Level Provider

Name: _____
Supervising Provider

I, _____, M.D./D.O. supervising Provider for the above named Mid-Level Provider, do hereby make the following statements of agreement in accordance with the policies/procedures regulating the Mid-Level Provider program:

1. I hereby accept full legal and ethical responsibility for the performance of all duties and acts performed by the above named Mid-Level Provider whom I have employed.

2. I hereby request approval to allow above named Mid-Level Provider to perform, outside my immediate supervision, the specific activities and duties, as outlined in the ***attached supervising guidelines and/or job description of the Mid-Level Provider***.

3. I agree to immediately notify IPA/Medical, in writing, in the event my approval to supervise an Mid-Level Provider is removed, limited or otherwise altered by action of the Medical Board of California, or in the event of any notification of investigation of my supervision by the Board, or if there is a change in employment status of the Mid-Level Provider hereby applying.

4. I agree to inform all patients that said Mid-Level Provider will participate in the total care of the patient and agree to ensure that the Mid-Level Provider will be clearly identified by badge.

5. I agree to comply with all regulations and policies of the Medical Board of California and/or other regulating agencies and IPA/Medical with respect to the supervision of the Mid-Level Provider, specifically including such regulations and policies which have been or may, from time to time, be adopted by said Board and/or other regulating agencies and IPA/Medical with respect to:

   a. Billing for the services of the Mid-Level Provider;

   b. Requirements for supervision of the Mid-Level Provider with respect to the type and scope of services approved by the Medical Board of California for the Mid-Level Provider to perform; and

   c. Requirement for identification of the Mid-Level Provider while rendering services.

   It is understood that compliance with such regulations shall be considered a necessary but not sufficient condition for the continuing approval by IPA/Medical of the performance of services by the Mid-Level Provider for the health plan.

6. I understand the right of the Mid-Level Provider to render medical services under my contract shall be contingent upon my continued membership and contract with IPA/Medical. If I terminate my membership or contract, or if my membership or contract is suspended, revoked or terminated, the Mid-Level Provider's clinical activities shall automatically be changed accordingly. Similarly, if my membership or contract is restricted, the Mid-Level Provider's activities shall be restricted accordingly.

7. If applicable, a certificate issued to me by the Medical Board of California indicating my approval to supervise an Mid-Level Provider in the type and scope of practice for which this application has been made is attached.

8. I understand that the above named Mid-Level Provider shall have only such authority as is necessary to perform the duties and tasks indicated in this application. Questions of authority shall be referred to me for case by case resolution.

_____ _____
Provider's Signature Date