BACK-UP SUPERVISING PHYSICIAN(S) FORM

(DO NOT SEND THIS FORM TO THE BOARDS)

NAME OF NURSE PRACTITIONER: ____

Keep a copy of this form on file at all practice sites for which it applies, as part of the inspectable supervisory arrangements statement described in Rule 21 NCAC 32M.0101(11) and 21 NCAC 36.801(11).

(1) ____ ________________________
(Signature of Back-up Physician) (Date)

(2)____ ________________________
(Signature of Primary Supervising Physician) (Date)

(3) ____ ________________________
(Signature of Nurse Practitioner) (Date)

(1) ____ ________________________
(Signature of Back-up Physician) (Date)

(2)____ ________________________
(Signature of Primary Supervising Physician) (Date)

(3) ____ ________________________
(Signature of Nurse Practitioner) (Date)

(1) ____ ________________________
(Signature of Back-up Physician) (Date)

(2)____ ________________________
(Signature of Primary Supervising Physician) (Date)

(3) ____ ________________________
(Signature of Nurse Practitioner) (Date)

(1) ____ ________________________
(Signature of Back-up Physician) (Date)

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(Signature of Primary Supervising Physician) (Date)

(3) ____ ________________________
(Signature of Nurse Practitioner) (Date)