ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

Under Alabama Law, this document is a public record and will be provided upon request

COVERING PHYSICIAN AGREEMENT

Email completed form to APPDept@albme.gov

As a covering (backup) physician providing oversight for _____, CRNP/CNM/PA (CRNP/CNM/PA or RA# _____), I hereby affirm that:

I will be readily available to collaborate with and provide medical oversight to the above-named advanced practice practitioner and, if indicated, to provide direct medical intervention to patients in the absence of the collaborating/supervising physician.

I am familiar with the current rules regarding Advanced Practice Nursing (Ala. Admin. Code Chapter 540-X-8)/Assistants to Physicians (Ala. Admin Code Chapter 540-X-7) and will abide by them.

I am familiar with the practitioner's standard protocols and any additional skills granted.

I will be accountable for adequate collaboration/supervision regarding the medical care rendered pursuant to the protocols and additional skills, if applicable.

I will approve the practitioner's prescribing of the drug types, dosages, quantities, and number of refills of legend drugs authorized in the standard formulary.

When the collaborating/supervising physician is not immediately available to respond to patient medical needs, the practitioner is not authorized to perform any act or render any treatments unless another qualified physician **is readily available to collaborate with/supervise the practitioner** and has previously filed with the Board this agreement.

During the temporary absence of the collaborating/supervising physician named below, I agree to assume those responsibilities for oversight and direction of the advanced practice practitioner enumerated in the collaboration/supervisory agreement with the collaborating/supervising physician.

Medical specialty of **covering** physician _____

Print **Covering** Physician Name _____ License # _____

Covering Physician Signature _____ Date _____

Covering Physician's Telephone Number _____ Fax _____

Collaborating/Supervising Phys. Name _____

Collaborating/Supervising Physician Lic. # _____

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.