



Banner Gateway
Medical Center

ALLIED HEATH PROFESSIONAL STATEMENT OF SPONSORING/SUPERVISING PHYSICIAN

I hereby request that _____, _____ who is applying for permission to provide patient care services as a _____

be granted permission to provide patient care services in accordance with the approved Delineation of Privileges set forth herein. The services set forth in the description are all within the scope of the Allied Health Professional's practice. I am familiar with the applicant's qualifications, character, current clinical competence, health status and believe that he/she is qualified to provide the services identified in the approved Delineation of Privileges. I further agree to supervise and to assume responsibility for supervision of the Applicant as set forth in this application.

Monitoring and reporting of the Applicant's performance will be performed. Reappointment will be based upon my recommendation as the Sponsoring Physician. I will return a completed evaluation form to attest to current competency as requested.

If malpractice insurance coverage is provided by my professional liability carrier, I agree to notify Banner Gateway Medical Center immediately upon notification by my carrier of any change that affects me or the applicant. I further agree to notify Banner Gateway Medical Center immediately if the sponsoring relationship with the Applicant is terminated or otherwise restricted in any way. Termination or suspension of the Sponsoring Physician's privileges will automatically result in the suspension of the AHP's privileges (until the AHP submits evidence of a new Sponsoring Physician in good standing).

Please Print Sponsoring/Supervising Physician's Name: _____

Signature of Sponsoring/Supervising Physician: _____

Date: _____

If an Independent or Group Practice, indicate other Sponsoring Physicians: