ADVANCED PRACTICE REGISTERED NURSE* (APRN) ATTESTATION FORM

*Certified Nurse-Midwife (CNM), Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS) and Clinical Nurse Specialist in Psychiatric/Mental health (CNS/PMH)

I, the undersigned Practitioner, hereby confirm that the following is true and accurate. I understand that if there are any changes or if any of the statements below are no longer accurate, I agree to provide written notice to Health One Alliance within three (3) days of any change.

Please initial the following statements or if non-applicable, indicate with "N/A".

Initials:

_____ I maintain a written Nurse Protocol Agreement with a Supervising/Delegating Physician that is a Participating Provider with Health One that satisfies the state law requirements.

_____ Pursuant to the Nurse Protocol Agreement, I am authorized to write prescriptions and I maintain a DEA Certificate in good standing.

_____ My Nurse Protocol Agreement is filed with the State licensure Board and has been approved by the State licensing Board.

_____ My Supervising/Delegating Physician has the same specialty and training as I do.

_____ My Supervising/Delegating Physician reviews a sampling of my charts in an amount that satisfies the state law requirements.

_____ My Supervising/Delegating Physician reviews all charts that contain controlled substance prescriptions.

_____ My Supervising/Delegating Physician reviews all charts where a patient has an adverse outcome.

_____ My Supervising/Delegating Physician is licensed in the State where I practice and readily available for immediate consultation.

I hereby acknowledge and agree that the above referenced attestations are true and accurate and shall remain accurate for so long as I participate as a Participating Provider in the Health One Network.

Participating Provider

Printed Name: _____

Signature: _____

Date: _____

Affirmed by Supervising/Delegating Physician

Printed Name: _____

Signature: _____

Date: _____