BlueCross BlueShield of Illinois

Supplemental Form for Physicians

Collaborating, Supervising or Monitoring Physician Protocols, Duties and Scope of Practice

Section 1: Collaborating, Supervising or Monitoring Physician and/or Sponsoring Institution

This form is for physicians who are statutorily required to be supervised or monitored by a physician licensed to practice in the state where they currently practice and who is designated as the primary collaborating or supervising physician. (An alternate physician can also provide supervision.) This form also specifies the sponsoring institution or location of appointment of study specific to a clinical subject or technique where applicable.

Applicant's name _____ **Degree** _____

Specialty _____

Collaborating/supervising/monitoring physician

Name _____

Degree _____

(This physician must be licensed and practice in the same state, the same networks and the same specialties as the applicant.)

Medical license No. _____ **State** _____

Alternate collaborating/supervising/monitoring physician (if applicable)

Name _____

Degree _____

(This physician must be licensed and practice in the same state, the same networks and the same specialties as the applicant.)

Medical license No. _____ **State** _____

Sponsoring institution/location of appointment (where applicable) medical center (sponsoring institution/location of appointment) _____**, located at (address of institution)**_____ **sets forth the terms and conditions of the affiliation between the parties with respect to participation between the site and participating physician.**

Section 2: Protocols, Duties and Scope of Practice

In my current position with _____ , collaborating/supervising/monitoring physician and/or sponsoring institution/location of appointment, I have reviewed, understand, agreed upon and signed along with my supervising physician, protocols or other written authorization that define my duties and role as a physician in a manner that promotes professional judgment commensurate with my education and experience. A copy of the protocols/duties/scope of practice is maintained onsite at my primary office location.

Attestation: I certify the information provided by me on this document is true, correct and complete to the best of my knowledge and belief. I understand and agree that any misstatement or omission of information concerning my collaborating/supervising physician and the established protocols/duties/scope of practice may constitute grounds for withdrawal of the application for consideration.

Applicant signature _____ **Date** _____

Printed name _____