NCMB Compliance Request

Practice Site Approval Request

Licensee Name *(full name and license type)*: _____

License #: _____

NCMB Case # *(if known)*: _____

Best Contact Phone # / Email Address: _____

Name of Practice Site for Consideration: _____

Address of Practice Site for Consideration: _____

Name of Point of Contact at Proposed Practice Site: _____

Contact Phone # / Email Address of Point of Contact: _____

Your Intended Area(s) of Practice: _____

List of Duties and Job Title at Practice Site for Consideration: _____

_____

_____

_____

_____

_____

_____

How many hours in an average week will be spent involved in patient care? *(this includes charting and image reading)* _____

Attestation

I attest that the Point of Contact for the Practice Site listed above has been provided with a copy of and has read my Reentry Agreement, which includes a provision requiring practice site approval.

You are signing this Practice Site Approval Request and attesting that the information that has been supplied by you is accurate and correct, to the best of your knowledge.

Signature: _____ Date: _____