



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: \_\_\_\_\_