NCMB Compliance Request

Supervisor Approval Request

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

License #: _____

NCMB Case # *(if known)*: _____

Best Contact Phone # / Email Address: _____

Name of Proposed Supervising Physician: _____

Proposed Supervising Physician License #: _____

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

Board Certification / Area of Practice of Proposed Supervising Physician: _____

Email Address of Proposed Supervising Physician: _____

Attestation

I attest that the Proposed Supervising Physician listed above has been provided with a copy of and has read my Consent Order, which includes a provision requiring physician supervision, and has agreed to serve as my supervising physician.

You are signing this Supervisor 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: _____

Proposed Supervising Physician

Signature: _____ Date: _____

Once complete, please email to boardmonitoring@ncmedboard.org