North Carolina Perfusion Advisory Committee

DESIGNATION OF SUPERVISING PERFUSIONIST FORM

Form(s) must be originals, typewritten or neatly printed
FAXED FORM(S) WILL NOT BE ACCEPTED!

I. PROVISIONAL PERFUSIONIST INFORMATION:

Full Name: ____
(First) (Middle) (Last)

*Name of practice: ____

*Practice address: ____
(Street) (City, State, Zip)

*Practice phone #: ______________________ Home phone #:___________________

*Practice fax #: _________________________ Home fax #: ______________________

Preferred mailing address ______home ______work

Preferred public address ______home ______work (will be listed on the internet)

County in which primary practice is located_______ County in which you live________

***Please attach on a separate sheet listing any additional practice sites.**

II. PRIMARY SUPERVISING PERFUSIONIST INFORMATION:

Primary Supervising Perfusionist name: ____

Name of perfusionist's principle practice: ____

Practice address: ____
(Street) (City, State, Zip)

Practice Phone # ___________________ Practice Fax # _____________________

III. CERTIFICATION OF UNDERSTANDING AND COMPLIANCE:

The undersigned applicant has read this form and certifies that the information contained herein is correct to the best of his/her knowledge.

The undersigned supervising perfusionist accepts responsibility for the applicant's conduct as a provisional perfusionist under the perfusionist's supervision and understands that conduct which violates the laws governing perfusionists may subject the supervising perfusionist to sanctions including suspension or revocation of the perfusionist's license to practice perfusion in North Carolina.

____
Date

____
Applicant/ Provisional Perfusionist (original signature)

____
Full Name Typed or Printed Legibly

____
Date

____
Primary Supervising Perfusionist (original signature)

____
Full Name Typed or Printed Legibly