(S A M P L E)

Non-Physician Medical Practitioners Agreement

The following is an agreement between _____ and
(Clinician Name)

_____.
(Supervisory MD or Medical Director)

The undersigned Non-Physician Medical Practitioners (NPMP) acknowledges the following:

I agree to follow the protocols established by _____
(Name of Practice or Organization)
for NPMP practice.

I understand that failure to follow these protocols may result in disciplinary action.

I agree to consult with my supervising physician for all cases as outlined in the protocols and for any case if I am unsure about the diagnosis or management.

I understand that I must maintain my current state license and must participate in Continuing Medical Education relating to my specialty, in accordance with the license and certification requirements applicable to my specialty.

I understand that a supervising physician will be available either on-site or by electronic communication at all times while I am caring for patients.

I understand that I am expected to stabilize patients during life-threatening emergencies and to contact a physician as soon as possible and/or arrange for emergency transport to the nearest hospital.

I understand that my charts will be reviewed by the supervising physician who will discuss cases with me on a regular basis.

I understand that medications must be ordered pursuant to applicable provisions of applicable California and Federal laws relating to my specific certification or licensure.

I understand that _____ is the provider for purposes of delivering medical services,

determining fees, billing patients and setting office practices and procedures. I further agree that the salary or wages I receive from said provider constitutes payment in full to me for the services rendered to said provider's patients.

This agreement is effective until amended in writing or terminated by the supervising physician, and shall automatically terminate when the NPMP no longer provides services in the practice.

Name of NPMP (typed or printed)	Signature	Date
Name of Supervising Physician or Medical Director (typed or printed)	Signature	Date