623 SW 10th Avenue
Topeka, KS 66612
800.232.2259
www.kammco.com

Statement of Supervising/Responsible Physician

(This statement must be completed, signed, and returned with your completed application.)

Applicant's Name: _____ **License Number** (if applicable): _____

Supervising/Responsible Physician Name: _____

1. Provide a description of the physician's practice and the way in which the applicant is to be utilized—include applicant's routine duties, the type of practice, and the practice setting.

2. Identify the practice location(s) at which the applicant will routinely render professional services. Include hospitals, if applicable.

I understand the supervising/responsible physician will always be available for communication within thirty (30) minutes during the performance of patient service.

I have carefully read the above questions and have answered them completely, and my answers and all statements contained herein are true and correct.

_____ _____

Supervising/Responsible Physician's Signature **Applicant's Signature**

_____ _____

Date **Date**