**NP/PA Student - Supervising Physician Attestation**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates for clinical hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

This letter is to inform you that the above referenced student at **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (School Name)** will be completing a rotation with me at The Hospitals of Providence. I understand I am responsible for the education of the student in my charge. I have signed an agreement/contract with the school to provide educational opportunities.

I take responsibility for educating the student regarding clinical policies and procedures at The Hospitals of Providence and to abide by all provisions set forth in the Affiliation Agreement. I will take responsibility for the actions and behaviors of the student while on the premises.

I further understand the scope of practice of students and agree to abide by such requirements. I will abide by all clearance requirements. I will not ask the student to participate in clinical activity at any facility that I do not have active medical privileges while under my supervision.

(The physician that signs off for the NP or PA who will supervise your work must sign this agreement, as well as the supervising NP/PA)

*Physician name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_*

*NP/PA Supervisor (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NP/PA Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_*

*NP/PA Supervisor (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NP/PA Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_*

*NP/PA Supervisor (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NP/PA Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_*