St. Dominic's

Sponsoring Physician Statement

******Please complete separate form for each practice location.******

Name: _____ Title: _____

Practice Location: _____

I request permission for the above-named applicant to assist me with my patients at St. Dominic-Jackson Membership Hospital.

I hereby verify that the above-named application will be under my direction at all times and I agree to assume full responsibility for his/her actions in dealing with my patients who are hospitalized at St. Dominic- Jackson Memorial Hospital. I also agree to notify the Hospital if this person should ever terminate.

I hereby request that the applicant be allowed to assist me at St. Dominic-Jackson Memorial Hospital. I will provide the following assurances and information below:

1. The applicant is currently employed, contracted, or sponsored by me and/or my group.

2. My professional liability insurance policy provides coverage for this person's patient care activities while at St. Dominic-Jackson Memorial Hospital.

   Insurance Carrier Name: _____

   Effective Date: _____ Policy Limits: _____

   -OR-

   The applicant will provide his/her own coverage for patient care activities at St. Dominic-Jackson Memorial Hospital.

   Insurance Carrier Name: _____

   Effective Date: _____ Policy Limits: _____

3. The applicant will conduct him/herself in a professional manner in all patient and staff interactions.

4. I understand that at no time may the applicant perform or function, in a manner which would constitute medical practice, and that all duties performed by the applicant must be done under my supervision and upon my authority. I assume all responsibility and liability for applicant's actions while providing services to my patients and accountability for applicant's conduct within St. Dominic Hospital.

5. I have reviewed the job description submitted by the applicant. I verify the applicant is able to perform the services request and hereby attest to the applicant's clinical competence.

Signature of Employing/Sponsoring Physician(s):

Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date