COMMUNITY HEALTH CENTER NETWORK

SUPERVISING PRACTITIONER VERIFICATION FORM

Please forward to your designated Supervising Practitioner. This practitioner must be contracted and credentialed with Alameda Alliance for Health.

I, ____ am the Supervising

Practitioner for ____.

I also have privileges at the following participating facility/facilities:

(1) ____

(2) ____

(3) ____

__________________________________ __________________

Signature of Supervising Practitioner **Date**

__________________________________ __________________

License Number of Supervising Physician **NPI Number of Supervising Physician**