SIERRA HEALTH SERVICES, INC.

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APN/PA COMPETENCY STATEMENT and SPECIALTY ATTESTATION

The purpose of this form is to assess the APN/PA's ability to deliver care required in the requested healthcare service contract.

SECTION I: to be completed by APN/PA

I, _____, APN/PA attest that I will provide professional care as reflected in the Practice Protocol/Job Description which reflect my education specialty of _____, and these services comply with state and federal law.

_____ _____.
Signature of APN/PA DATE

SECTION II: to be completed by APN/PA's Collaborating/Supervising physician.

I, _____, attest the APN/PA named above ☐**is** ☐ **is not**
(Name of Collaborating/Supervising Physician)
competent to provide professional care as reflected in the Practice Protocols/Job Description which reflect the education specialty of:_____**,** and
(Education Specialty)
these services comply with state and federal law.

My assessment of this competence is supported by:

☐ Education_____

☐ Experience_____

☐ OJT/CME, etc._____

_____ _____.
Signature and Title of Collaborating/Supervising Physician DATE

PHYSICIAN'S PRIMARY ADDRESS: _____

_____
CITY STATE ZIP

***SHS must be notified of any change in Collaborating/Supervising Physician.**
Please fax to: 702-242-7853