



STATEMENT OF SPONSORING PHYSICIAN

This form must be completed and signed by each sponsoring physician.

However, if sponsorship is by a contracted group for services (i.e., emergency, imaging, anesthesia services), the physician medical director of the group may sign as the single sponsor for the group.

The herein listed sponsoring physician(s) for applicant acknowledge that the AHP will function under his/her supervision and sponsorship in the hospital setting under his/her supervision at all times, and said sponsor(s) agree to assume full responsibility while practicing within Broward Health. Sponsor(s) is obligated and agrees to notify the CDQ immediately upon termination of sponsorship and supervision, for any reason.

AHP Name: _____

Scope of practice under sponsor(s) supervision: *Must attach a copy of protocol on file with the state licensing agency, if required to file such protocol. A copy of any updated protocols must be provided to the CQD within 5 business days of filing with the state licensing agency.*

- The applicant provides his/her own liability coverage, as attested to by copy of the malpractice verification of coverage. *copy attached*
- The applicant is covered under my liability coverage, as attested to by copy of the malpractice verification of coverage. *copy attached*
- The applicant is not covered by liability coverage, will function under my direct supervision, and I assume complete liability of said applicant while functioning in Broward Health under my supervision and sponsorship.

Sponsor Name	Sponsor Signature	Date Signed