To: Alabama Board of Medical Examiners

LPSP Covering Physician Agreement

As a covering (back-up) physician providing medical direction and oversight for _____, ____PA ____CRNP/CNM (choose one), by signing this document, I hereby affirm that:

1. I am familiar with the Board rules regarding the mid-level practitioners and their ability to prescribe Schedule II controlled substances with a Qualified Alabama Control Substance Certificate (QACSC).
2. I am approved as a covering physician for the mid-level's QACSC.
3. I am familiar with the Board Rules governing the Limited Purpose Schedule II Permit (LPSP).
4. I have a current and unrestricted Alabama Controlled Substance Certificate, #_____.
5. I will be accountable for adequately providing medical direction and oversight for the prescribing of the Schedule II controlled substances allowed under this LPSP.
6. I will assume all responsibility for the controlled substance prescribing of the mid-level practitioner during the temporary absence of the primary Collaborating/Supervising Physician.

Telephone number _____ Fax Number _____

Medical Specialty of the Covering Physician _____

_____ _____

Print Physician Name Physician License #

_____ _____

Physician Signature Date