



PRACTICE PLAN APPLICATION

**Specific practice plan requirements are outlined in your individual order or agreement. A new practice plan must be submitted anytime there is a change in your employment status and/or practice setting.*

Practitioner Background:

Name: _____

License Type: _____

Previous Areas of Practice & Board Certification/Training: _____

Practice Information:

Practice Type: _____

Area of Specialty: _____

Anticipated Duties: _____

Anticipated Work Hours: _____

Practice Hours: _____

Anticipated On Call Duties: _____

Anticipated Average Number of Patients Per Day: _____

Practice Address(es): _____

Practice Owner: _____

Number of On Site Staff and Clinical Duties: _____

Chaperone Availability (If Required): _____

Monitoring Physician on Site: _____

Number of Charts for Review: _____

Additional Practice Information:

Printed Name

Signature

Date

Contact Information (Email and Phone Number)

Should you have additional questions. Please contact Compliance Officer, Angela Sturgeon, at angela.sturgeon@med.ohio.gov or Compliance Supervisor, Amy Pridday, at amy.pridday@med.ohio.gov.