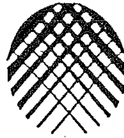

QUALCARE™
PREFERRED PROVIDERS

Statement of Collaboration

This statement certifies that:

______________________________________ is employed by
(Nurse Practitioner/Physician Assistant/Midwive)

______________________________________ who practices as a
(Group/Physician)

__________________________ and will supervise medical services
(Specialty)

provided to QualCare members as defined by the State of New Jersey.

____
Physician Signature

____
Physician Name (printed)

Date: ______________