

**MARYLAND BOARD OF PHYSICIANS**  
**P.O. BOX 2571**  
**Baltimore, MD 21215**  
**410-764-4775**  
[www.mbp.state.md.us](http://www.mbp.state.md.us)

**DESIGNATED ALTERNATE SUPERVISING PHYSICIAN FOR ATHLETIC TRAINERS**

**Instructions and Important information:**

- ⇒ Supervising physicians, athletic trainers and alternate supervising physicians complete and sign the appropriate sections.
- ⇒ The supervising physician may designate more than one alternate supervising physician to supervise the athletic trainer in his/her absence. The designated alternate supervising physician must supervise the athletic trainer in accordance to the Evaluation and Treatment Protocol on file with the Board.
- ⇒ Complete a form for each designated alternate supervising physician.
- ⇒ Make as many blank copies of the form as necessary.
- ⇒ **Please be sure that all signatures are original. The Board will NOT accept copies of signatures.**

**1. ALTERNATE SUPERVISING PHYSICIAN INFORMATION:**

Name of Alternate Supervising Physician:	Maryland License #:
Work #:	Cell #:
Pager #:	Email Address:

**2. ATHLETIC TRAINER AND SUPERVISING PHYSICIAN INFORMATION:**

Name of Athletic Trainer:	Name of Supervising Physician:
Signature of Athletic Trainer:	Signature of Supervising Physician:

**3. ALTERNATE SUPERVISING PHYSICIAN PLEASE ANSWER “YES” OR “NO”**

Have you ever been subject to public disciplinary action in any jurisdiction by any licensing or disciplinary board or an entity of the armed services?

Yes

No

If you answered “YES,” provide a detailed explanation and supporting documentation on a separate sheet of paper. Be sure to sign and date all documentation. *(Failure to provide an explanation or supporting documentation will delay the processing of this application.)*

**4. AFFIRMATION**

I accept the responsibility of supervising the listed athletic trainer, in accordance with the approved Evaluation and Treatment Protocol, in the absence of the listed supervising physician. I solemnly affirm under penalties of perjury, that the contents of the foregoing document are true to the best of my knowledge, information and belief.

\_\_\_\_\_  
 Alternate Supervising Physician (Print)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Alternate Supervising Physician (Signature)