

**PROVIDER WEB PORTAL APPLICATION  
PHYSIOLOGICAL LABORATORY CERTIFICATION**

I, \_\_\_\_\_, hereby acknowledge that I agree to  
(Print or type Physician's name)  
provide general physician supervision in the areas of ultrasounds, Doppler services, and noninvasive  
peripheral vascular studies to :

\_\_\_\_\_  
(Name of physiological laboratory)

These responsibilities include, but may not be limited to, verifying periodically that the equipment is functioning properly and producing the quality of results expected. I also assume responsibility for following on a continuing basis those technicians doing ultrasound, Doppler testing, and peripheral vascular studies, and assisting them with any problems that may occur when providing these services. I will give direction and make recommendations to management regarding proper training or follow-up training.

\_\_\_\_\_  
Physician's Signature  
(Original signature required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Application Tracking Number

Submit with the bar coded cover sheet to the DXC Provider Enrollment Department  
at: P O Box 241685, Montgomery, AL 36124-1685