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Suite 100
Johns Creek, GA 30097
Phone: 678-417-8100
Fax: 678-417-8135
Email: specialtycaq@nccpa.net

ATTESTATION OF PA'S KNOWLEDGE AND SKILLS

I certify that PA ____, NCCPA ID #: _________________is able to apply the appropriate knowledge and skills needed for practice in **Palliative Medicine and Hospice Care** and has performed the following procedures and patient management relevant to the practice setting and/or understands how and when the procedures should be performed:

- Caring for the physical, psycho-social, cultural, and spiritual aspects of serious illness
- Providing pain and symptom management of serious illness to sustain comfort and function when possible and support quality of life
- Providing care in the context of formal or informal interdisciplinary teams to focus on the overall well-being of the patient (including non-physical domains of care), recognizing and facilitating necessary referrals as indicated
- Providing care for the patient and family in preparation for an anticipated death and in the management of the death event
- Demonstrated communication skills in caring for patients with serious illness and their families/caregivers
- Implementing a shared decision-making process with the patient to align current medical options for treatments and interventions with their values and preferences
- Assessing and supporting caregiver needs and coordination of care
- Assisting and guiding discussions with patients and their families in advance care planning and completing necessary documents
- Demonstrating knowledge of hospice care as an insurance benefit, hospice eligibility requirements and services provided

In addition, the PA should demonstrate an understanding of the principles of system-based practice, to include risk management.

I further certify that I am a physician, lead/senior PA, or physician/PA post graduate program director working in **Palliative Medicine and Hospice Care** or providing palliative medicine/hospice care services in a related discipline and am familiar with the PA's practice and experience in this specialty area.

Printed Name: ______________________________________

Title: ______________________________________

Signature: ______________________________________ Date: ____________________

I can be reached by NCCPA via the following for additional information or follow up:

Address: _______________________________________ Phone: _________________________

Email: _______________________________________ Fax: __________________________

PLEASE RETURN THIS FORM TO NCCPA VIA FAX, EMAIL OR MAIL TO THE CONTACT INFORMATION PROVIDED AT THE TOP OF THIS FORM.