DETAILS

Registrant designate name: _____

Non-hospital physician name: _____

Non-hospital facility name: _____

DECLARATION

The Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP) Committee requires that

Dr. _____ is aware of the responsibilities of being a registrant designate as outlined below:

I, Dr. _____ agree to cover for

Dr. _____ 's surgical patients from

_____ who may require further treatment and/or hospitalization. I understand my responsibility in the continuity of care for the above named physician's patients and have reviewed the related NHMSFAP Bylaws and policies.

SIGN OFF

Registrant designate signature: _____ Date: _____

Non-hospital physician signature: _____ Date: _____

Medical director signature: _____ Date: _____

Note: The signed form must be returned to the medical director and saved in the medical staff's human resources file.