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| **Figure 3.12** | **Physician Intended Practice Plan** |
| Applicant name, title (please print): Clinical specialty: Anticipated office address:  I will be practicing as a: solo practitioner group practitioner  If with a group, list group name:  I will admit patients in need of hospitalization to [Hospital name]. Yes No  If no, to what institution will you be admitting your patients? If yes, approximately how many patients per month will you admit?  I will perform procedures at [Hospital name]. Yes No  I will provide consultation at the request of other physicians at [Hospital name]. Yes No  If no, please explain.  List the physician(s) with whom you will share continuing coverage for your patients (must be a physician on staff at [Hospital name] in the same specialty):      I understand my answers to the above questions will be considered by [Hospital name] and that appointment, if offered, will be contingent on adherence to this practice plan.    Physician Signature Date | |