TOMBALL REGIONAL MEDICAL CENTER

**Physician Acknowledgement of Observation Procedure and Hospital Policy**

Name of Physician Seeking Observation_____
License Number _____
State _____ Expiration Date _____
Hospital(s) Currently Actively Credentialed _____
Board Certified _____
Date of Procedure _____
Procedure _____
Physician Performing the Procedure _____

I,_____, hereby certify that I am currently licensed in the State of _____ in good standing; am not currently and have never previously been suspended, excluded, or debarred from any government payor program; maintain valid liability insurance; am board certified in _____; and understand that the approval of Observation in no way permits me from providing treatment to any Hospital patient or having any of the privileges of Credentialed Physicians. I am seeking the Observation opportunity for legitimate professional development purposes. I agree not to hold Hospital, its employees, owners, directors and officers responsible or liable for any injury or damage I receive while on Hospital premises. Further, I acknowledge that I have read and understand Hospital's policy on Physician Observation of Medical Procedures (attached) and will comply with the same.

Signature _____ Date_____

**********For Hospital Use Only**********

Patient Consent Signed ___Yes ____ No
Non Credentialed Physician Given Hospital Observation Policy ___ Yes ___ No
Signature of Physician Performing the Procedure _____ Date _____
Signature of Medical Staff Coordinator _____ Date _____
Signature of Chief of Surgery_____ Date _____
Signature of Hospital CEO _____ Date _____