Texas Health
Harris Methodist Hospital
HURST-EULESS-BEDFORD

CALL COVERAGE AGREEMENT

Applicant's Name (Please Print or Type) ______________________ Applicant's Specialty/Subspecialty ______________________

INSTRUCTIONS TO THE PHYSICIAN APPLICANT - Please forward this form to the physician who has agreed to provide coverage for you. This form **MUST** be completed and signed by a physician who is currently a member of the medical staff and practices in the specialty/subspecialty in which you have requested privileges.

In accordance with the Medical Staff Bylaws of Texas Health Harris Methodist Hospital each Medical Staff Member agrees to provide continuous care for patients by having at all times on record in the Medical Staff Services office, the name of another member of the Medical Staff, in the same specialty and/or with similar privileges, designated and agreeable to provide alternate coverage for his patients; and agrees to notify the Medical Staff Services office of any changes in coverage. See excerpts from the Medical Staff Bylaws below:

2.2 General Criteria and Qualifications

2.2.10 Coverage. The Practitioner must demonstrate written arrangements for alternative medical coverage for patients for whom the Practitioner is or will become responsible by submitting written verification from an appropriately privileged Member who has agreed and is available to stand in the place of the Practitioner should the Practitioner be unavailable.

2.3 Duties and Obligations

2.3.2 Provide for the continuous care of the Member's patients by personally attending those patients or by arranging for appropriate coverage by another Member who holds the same or similar Clinical Privileges, as determined by the Medical Executive Committee subject to the approval of the Board of Trustees, during any time that the Member is not available;

The completed form must be submitted to the Medical Staff Office
via Fax Number 817-848-3390 or via Email Address hebmedicalstaffservices@texashealth.org

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This portion is to be completed by the physician agreeing to provide coverage. For those physicians in a group practice – each member of your group is required to sign this form if they will be providing coverage for you. A second page is attached for additional signatures.

I agree to provide patient coverage for the above named physician at Texas Health Harris Methodist H-E-B in the event that such physician is unavailable for the medical management of his/her patient.

____
Covering Physician's Name (Please Print or Type)

____
Covering Physician's Signature

____
Covering Physician's Specialty/Subspecialty

____
Date of Signature

____

Texas Health Harris Methodist Hospital HURST-EULESS-BEDFORD

CALL COVERAGE AGREEMENT (continued)

Applicant's Name (Please Print or Type) ______________________

Applicant's Specialty/Subspecialty ______________________

Each physician in a group practice with the physician applicant noted above and who has privileges at THHEB *and* who will provide coverage must sign and date below:

GROUP'S NAME: ____

#	Covering Physician's Printed Name	Signature	Date of Signature	Specialty / Subspecialty
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