INTENT TO USE HOSPITALIST GROUP FOR HOSPITAL ADMISSIONS

Date: ______________________

Practitioner Name: ______________________

Group Name: ______________________

Practitioner Address: ______________________

City, State, Zip: ______________________

Practitioner Specialty: ______________________

By submitting this form, I understand and agree to the following:

- **I do not currently hold admitting hospital privileges at any area hospital.**
- **I agree to have all hospital admissions for Sunshine Health patients via the hospitalist group Team Health.**
- **I understand all admissions will be done at participating Team Health hospitals.**

This form will allow you to utilize Sunshine Health's contracted hospitalist group, Team Health, to evaluate/ admit Sunshine Health members who may present in a hospital.

Please sign the consent at the bottom portion of this letter and fax to Sunshine Health at 866-534-5966.

______________________	______________________
Signature	**Date (mm/dd/yyyy)**