Anderson Healthcare

COVERING PROVIDER AGREEMENT

Applicant's Name:_____

In the space provided, please **PRINT** the name of the provider, who has agreed to provide coverage in your absence. Please note that your covering provider must hold equivalent privileges at the Anderson Healthcare Entity to which you are applying. If a group practice is providing your coverage, please **PRINT** the name of the group and have one person from that group sign as a representative in the covering provider section.

_____
Printed Name of Alternate

This section to be completed by your covering provider:

I acknowledge that by signing below, I agree to serve as the covering provider of the above-referenced Medical Staff member. I also acknowledge that I have read and understand the covering provider's responsibility as outlined below:

_____ _____
Covering Provider's/Group Representative Signature Date

_____
Group Name – if applicable

Covering Provider's Responsibility

I understand the responsibility of a covering provider is to provide coverage for patients, inpatient/outpatient procedures and for consultation purposes when the above-named-provider has requested such coverage.