

**PHYSICIANS CONTRACTING ORGANIZATION OF TEXAS**

**HOSPITAL PRIVILEGE WAIVER**

Recognizing that \_\_\_\_\_ (provider name) does not have admitting privileges to a participating facility due to an office/clinic based practice, it is agreed by the undersigned that all admitting, inpatient and outpatient facility based services and therapies will be provided by \_\_\_\_\_ (physician or hospitalist group)

Emergency care for the stabilization of patients will be provided at the closest facility, but immediate transfer to participating facility should occur upon stabilization.

PHYSICIAN

PHYSICIANS CONTRACTING ORG. OF TEXAS

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Credentialing Committee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date