

Physician Acknowledgement Report

Date: _____

Hospital Name: _____

Hospital Number: _____

Physician NPI: _____

Date Physician Granted Admitting Privileges: _____

Date Physician Signed Statement: _____

Mail to: (Attach a copy of the signed acknowledgement statement)

FMQAI
5201 W. Kennedy Blvd. #900
Tampa, FL 33609
Attn: Case Review Project Director