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# Memorial Hermann Memorial City

## MEMORIAL STAFF EMERGENCY CENTER CALL AUTHORIZATION FORM FOR ASSIGNED PATIENTS

I, \_\_\_\_\_, request Memorial Hospitalist Group to see  
(designating physician) accepting physician(s)  
my patients that present at MHMCMC's ER when I would be called for inpatient care. My  
designation will remain in effect until Memorial Hospitalist Group or I notify the ER  
accepting physician(s)  
in writing of any change.

\_\_\_\_\_  
Signature of Designating Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Designating Physician

We, Memorial Hospitalist Group agree to see the assigned patients of Dr. \_\_\_\_\_,  
accepting physician(s) (designating physician)  
that present to the MHMCMC's ER and we agree to provide appropriate medical care.  
Our acceptance will remain in effect until Dr. \_\_\_\_\_ or we notify  
(designating physician)  
you in writing of any change.

\_\_\_\_\_  
Signature of Accepting Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Accepting Physician

**Fax to 713-973-0805  
or email to: [err@traveldoc.com](mailto:err@traveldoc.com)**