



# CHAPTERS HEALTH<sup>®</sup> SYSTEM

GOOD SHEPHERD HOSPICE • LIFEPAATH HOSPICE  
HPH HOSPICE • HPH HOME HEALTH • PALLIATIVE CARE

## **Acknowledgement of Chapters Health System Community Provider Education**

By checking the appropriate box below and typing/signing my name, I acknowledge that I have reviewed and understood the required education components provided.

### ***Attending Physicians/ARNPS/Consulting Providers***

I have completed the following three education modules:  
Chapters Health System Overview, Hospice Eligibility and GIP Eligibility

### **Inpatient Unit Provider Education and Overview**

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

These documents may be submitted electronically by email to [medcredentialing@chaptershealth.org](mailto:medcredentialing@chaptershealth.org) or by fax to 813-533-0493.