Facility Name			
Facility Address			
Proposed Meeting Day(s)			
Proposed Meeting Time			
Contact Name			
Contact Email			
Contact Phone			
outside meetings." (Policy Gui	•	es where the patients do not have access to our facility meet this criteria:	to
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outside meetings." (Policy Gui	delines, pg. 25) Does y	our facility meet this criteria:	to
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Dutside meetings." (Policy Guing YES)  NO OTHER:  To be completed by H&I Area  Test Date:  # of Attendees:	FORM TO: hospitals Supervisor or Hospital Day:	@lahic.org  S Director)  Time:	to

**New Panel Request Form** 

DATE SUBMITTED: \_\_\_\_