


# ST. JOSEPH'S

Hospital  Health Center

## REVISION OF PRIVILEGES

To be completed by a practitioner requesting a revision of his/her privileges at times other than at appointment or reappointment.

Name (please print): \_\_\_\_\_

Are you now or were you subject to (within the past two years): Please provide full details for positive answers on a separate sheet.

- |                                                                                                                                                                                                               | <u>YES</u> | <u>NO</u> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 1. Limitation, suspension, probation, revocation, denial, non-renewal or voluntary surrender of employment, appointment, privileges or training at any hospital or health care related institution?           | _____      | _____     |
| 2. Withdrawal of your application for appointment, reappointment or clinical privileges or resignation from a medical staff before a decision was made by a hospital or health care facility governing board? | _____      | _____     |
| 3. Pending professional malpractice claims or actions, medical conduct proceedings or licensing board actions in any jurisdiction?                                                                            | _____      | _____     |
| 4. Any judgment, settlement or findings of medical malpractice or any findings of professional misconduct in any jurisdiction?                                                                                | _____      | _____     |

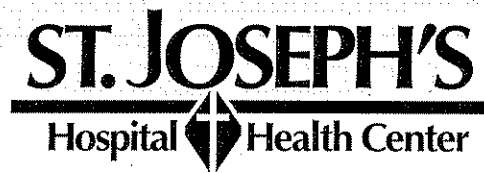
The undersigned hereby affirms that the above responses are complete, true and accurate to his/her own knowledge and belief.

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

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

Reviewed: \_\_\_\_\_

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



Name: \_\_\_\_\_

**NEW PRIVILEGE REQUEST**

**REQUESTED**

**APPROVED**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In requesting the aforementioned privilege and/or procedure, I certify that I have had appropriate experience and/or training in diagnosing and managing and performing the above.

**Signature of Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Based upon review of the physician's training, education, knowledge, current competence and health status, the clinical privileges, as indicated, are recommended.

**Signature, Chairperson of Department:** \_\_\_\_\_ **Date:** \_\_\_\_\_