



Dear Provider:

Please mark as appropriate below.

_____ **I would like to maintain my privileges as requested previously. I do not wish to make any revisions to my privileges at this time.**

_____ **Please make the following additions/deletions to my privileges (please provide documentation for any additional privilege requests):**

_____ **I would like to resign my privileges and medical staff membership at this time.**

(If you check this line, please fax this page only to Rose Delaney at (985) 690-7778 as soon as possible.)

Signature

Date

Printed Name

Department Chairman

Date