

**REHOBOTH MCKINLEY CHRISTIAN HOSPITAL
CLINICAL PRIVILEGES APPLICATION**

MISCELLANEOUS PRIVILEGES

NAME: _____

SPECIALTY: _____

PLEASE LIST PRIVILEGE(S) YOU ARE REQUESTING, INCLUDING
YOUR TRAINING AND/OR EXPERIENCE (NUMBER OF CASES)

PRIVILEGES

RECOMMENDED

YES NO

Training/Experience: _____

___ ___

Training/Experience: _____

___ ___

Training/Experience: _____

___ ___

Training/Experience: _____

___ ___

Training/Experience: _____

___ ___

Training/Experience: _____

___ ___

IF ADDITIONAL SPACE IS NEEDED, PLEASE PROVIDE A BRIEF NARRATIVE ON A
SEPARATE SHEET.

APPLICANT SIGNATURE: _____

DATE: _____

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NAME:

STATEMENT OF SUPERVISING/DIRECTING PHYSICIAN: SEE BYLAWS, SECTION 5.3(a)

I hereby certify that the applicant is duly qualified and licensed to perform the requested privilege(s) under my supervision or the supervision of my designee.

NAME OF SUPERVISING/DIRECTING PHYSICIAN: _____

PHYSICIAN SIGNATURE: _____

DATE: _____

DEPARTMENT REVIEW:

Comments/Recommendations/Suggestions:

SIGNED: _____

Department Chairperson

Date of Review

Medical Staff Department

MSS:REVISED 09/99.