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| **Practitioner Name** |  | **Date** |  |
| **Specialty** |  | | |
| **Supervising Physician if APP** |  | | |

**I HEARBY REQUEST THE FOLLOWING NEW PRIVILEGE(S):**

In making this request, I acknowledge that it is my responsibility and I agree to submit all appropriate and requested documentation verifying my training, experience, and demonstrated competency. This may include any evidence as requested of me by any committee delegated the responsibility of reviewing requests for privileges, the Chairman or Vice-Chair of the appropriate Division, Medical Executive Committee, Hospital Administration or the Board of Directors.

I hereby authorize Huntington Health and any of its representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my licensure, training, experience, professional competence, character, health status, ethical, and other qualifications.

I hereby release from any liability any and all individuals and organizations who provide information to Riverside Medical Center concerning my licensure, training, experience, professional competence, ethics, character, health status, and other qualifications demonstrating my ability to perform the privileges requested. I hereby consent to the release of such information.

If granted clinical privileges, I specifically agree to release from liability, all representatives of the hospital and its medical staff for their acts performed in connection with all credentialing activities, including appointment and reappointment, granting of new or additional privileges, corrective action, based upon quality assurance, risk management, utilization review or compliance with the Bylaws, Policies and Procedures.

I understand that I have the burden of providing adequate information to Riverside Medical Center to demonstrate my qualifications. If this information is not provided in a timely manner, I understand that my application shall be considered withdrawn from consideration.

I have enclosed documentation of my training, experience, and demonstrated competency including but not limited to activity logs, a description of my training/coursework related to this procedure, course syllabus or certificate if available, any CME related to the privilege(s) requested

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| **Practitioner Name** |  | **Date** |  |
| **Practitioner Signature** |  | | |

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| **Supervising Physician Name (if applicable)** |  | **Date** |  |
| **Supervising Physician Signature (if applicable)** |  |  |  |