

Shands HealthCare

Medical Staff Resignation/Status Change Form

Updated 10/17/08

Please complete all items:

Date Submitted: _____ Effective Date: _____

Practitioner Name: _____

Department (if applicable) _____

Individual Submitting Form: _____

Instructions: Complete the change desired as instructed. Have the practitioner and the practitioner's Department Chair or President of the Medical Staff (as applicable) sign the form. Submit the form to Laura Quintana, Credentialing Verification Office, Box 100371, Gainesville, FL 32610-0371. Please note the change will go into effect after approval by the Board.

Additional Privileges: Please indicate the requested additional privileges and complete the following pages.

Status Change or Campus Change: please check the practitioner's current status and the status the practitioner would like to become.

Status Change		Campus Change	
From	To	From	To
<input type="checkbox"/> Active	<input type="checkbox"/> Active	<input type="checkbox"/> AGH	<input type="checkbox"/> AGH
<input type="checkbox"/> Courtesy	<input type="checkbox"/> Courtesy	<input type="checkbox"/> UF	<input type="checkbox"/> UF
<input type="checkbox"/> Consulting	<input type="checkbox"/> Consulting		
<input type="checkbox"/> Honorary	<input type="checkbox"/> Honorary		
<input type="checkbox"/> Leave of Absence	<input type="checkbox"/> Leave of Absence: From _____ To _____		

Resignation: Circle all the facilities/programs from which you wish to resign:

Shands @ AGH/UF Shands Lake Shore Shands Starke Shands Live Oak Shands Network

Department Change: Please indicate the department to which you request to be assigned.

Practitioner Signature

Date

Department Chair or President of the Medical Staff (as appropriate) Signature

Date

Request for Additional Privileges

Please complete a separate form for each new procedure/privilege requested.

Printed Name _____

Procedure/Privilege _____

Experience: Complete the applicable sections below documenting your current competence and ability to perform the requested procedure/privilege(s). **You must complete a new form for each new procedure/privilege requested.**

	Number of cases/procedures you performed during the past two (2) years.
	Approximate date you last performed this procedure.
	Name of hospital/facility where you last performed this procedure.

Describe any complications you encountered while performing this procedure:

Formal Training / Education: Complete the applicable sections below documenting your current competence and ability to perform the requested procedure/privilege(s).

	Name of residency/fellowship (hospital) where you received training, for these additional procedures/privileges.
	Name and date of educational seminar, approved by an accredited CME provider, you attended to receive your primary education in this procedure. (Attach certificate of completion.)
	Title and date of any relevant CME activities you have completed recently.
	Name and address of the qualified Preceptor who provided you with training. (Attach any relevant documentation of training for procedure(s) requested.)
	Date you completed any relevant training for the privilege/procedure requested.

I am requesting only those specific privileges for which: by education, training, current experience and demonstrated performance, I am qualified to perform. I attest by signature that I have and will continue to meet the minimum criteria of procedures/diagnoses management.

Medical Staff Member/AHP's Signature

Date