London Health Sciences Centre

St Joseph's Health Care London

CONSENT FOR RELEASE OF CREDENTIALS FILE

I, Doctor ______________________ consent to the release of the following information:

Application for privileges	❒ Yes	❒ No
Most recent reapplication for privileges	❒ Yes	❒ No
Reference letters	❒ Yes	❒ No
Letter of support from Chief	❒ Yes	❒ No
Certificate of Professional Conduct from CPSO	❒ Yes	❒ No
N95 Fit Test	❒ Yes	❒ No
Health Review	❒ Yes	❒ No

Other: Letter of Good Standing ______________________________________

TO: ____

(name of contact)

Organization Name: ____

Organization's Address: ____

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Telephone Number: ____________________ Fax Number: ___________________

❒ By checking this box, I ________________________ consent to have the above noted information released.

Date: ______________________________

Please return to: **Medical Affairs**
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Phone: (519)685-8500 x75127 or Fax: (519)667-6844
Medical.Affairs@londonhospitals.ca