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| DEPARTMENT CHIEF SUPPORT FOR APPOINTMENT | | | | | | | | | | |
|  | | |  | | | | | | | |
|  | Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Anticipated Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **PRIVILEGE INFORMATION** | | | | | | | | | |
|  | **Hospital**  **(LHSC or St. Joseph’s)** | | **Primary Practice Site**  **(VH, UH, VFMC, SJH, etc. )** | **Credentialed Professional Staff Category** | **Admitting Privileges**  **Yes or No** | **Department** | **Division** | | **Delineation of Privileges Categor(ies)** |
| **Primary** |  | |  |  |  |  |  | |  |
| **Secondary** |  | |  |  |  |  |  | |  |
| **Cross**  **\* See below for signature** |  | |  |  |  |  |  | |  |
|  | Check this box to confirm that the delineation of privileges category listed in the above table is aligned to the applicant’s    education and training. To review the delineations click [here](https://www.sjhc.london.on.ca/medical-affairs/delineation-of-procedural-privileges) | | | | | | | | | |
|  | Check this box if the Professional Staff appointment is for a physician also training as a resident or clinical fellow to confirm that the appointment has been approved by the Program Director/Supervisor. | | | | | | | | | |
|  | **ROLE DESCRIPTION and RESPONSIBILITIES** | | | | | | | | | |
| **Western University Appointment and Rank** | | | | | | | | | |
| **Clinical Role Description** Please provide a description of the clinical role that the applicant will undertake in the department. | | | | | | | | | |
| **Name of Probationary Supervisor for Associate category appointments only** | | | | | | | | | |
| **DECLARATION AND APPROVAL** | | | | | | | | | |
| **I support the request for appointment for the above named applicant to the credentialed professional staff to move forward for recommendation by the City-Wide Credentials Committee and subsequently for approval by the Medical Advisory Committee and Boards of Directors. I confirm that there is no conflict of interest with my support of this applicant and understand that any misrepresentation of information on this form may be grounds for denial of appointment.** | | | | | | | | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_**  **Signature of Department Chief for Primary appointment / Please Print Name After Signature**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\* Signature of Department Chief for Cross appointment/ Please Print Name After Signature**  **(if a cross appointment is being issued)** | | | | | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date** | |