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**APPOINTMENT CHANGE SUPPORT FORM**

This form is to be completed by the Department Chief to **request a change** to an existing clinical appointment for a Credentialed Professional Staff (Professional Staff) in their department by completing **PART A**. A change can occur as an adjustment to their clinical privileges (ie. Active to Modified-Active).  **PART B** is to be completed to notify Medical Affairs of a leave of absence greater than 60 days. **PART C** is to be completed to notify the hospital of a change to a Schulich School of Medicine and Dentistry academic appointment (ie., Clinical Academic to Clinical Post-Retirement) or a change to their Academic Role Category and confirm whether this change will or will not have an impact on the appointee’s current hospital appointment.

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| **Name:** Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first name) (last name) |
| **Department:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Division:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Effective Date for Change: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PART A – Change to the Primary and / or Secondary Hospital Clinical Appointment.****Please indicate below the proposed change(s) to the Primary and/or Secondary Hospital Clinical Appointment.** |
|  | **Hospital / Site(s)** | **Professional Staff Category** | **Admitting Privileges** | **Department** | **Division** | **Delineation of Privileges Category** |
| 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. |
| **Please use this space to explain the change to the hospital appointment.** |

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| **PART B – Confirmation of a leave of absence greater than 60 days.****Please indicate below the anticipated start and expected date of return from the leave of absence greater than 60 days and check off the appropriate box to indicate the reason for the absence.** |
| Anticipated **Start** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Expected **Return** Date:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  **Illness Personal Education Sabbatical**  |
| **PART C – Change to the Schulich Medicine & Dentistry Academic Appointment or Academic Role Category.****Please indicate below the confirmation of the change(s) to the Schulich Medicine & Dentistry Academic Appointment or Academic Role Category. If the individual's clinical or academic role including Undergraduate or Postgraduate teaching and research has changed, the department leadership needs to consider if the clinical and academic deliverables of the department/division can continue to be fulfilled. A change to the physician’s Academic Role Category may impact resources.** |
| **Current** Western Academic Appointment: **New** Western Academic Appointment: **OR**Current Western Academic Role Category:New Western Academic Role Category:(For full-time faculty, please attach the new Academic Role Category document signed by all parties to this form) |
| **Please provide details that this change has to the following areas:**a) Clinical Volumes:  Increase Decrease No Change 1. Academic role including Undergraduate

 or Postgraduate teaching: Reduced Enhanced No Change  1. Academic role including research: Reduced Enhanced No Change

d) Hospital on-call responsibilities: Reduced No On-Call No Changed) Will this change require a replacement to be recruited: Yes No(For part-time or post-retirement appointments, please attach the Schulich Medicine & Dentistry Statement of Expectations and Responsibilities (SER) document signed by all parties to this form) |
| **PART D – Notification of Departure****Please indicate below the effective departure date to end hospital privileges.** |
| Hospital privilege end date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Note**: All systems access will be deactivated as of this date. Professional staff will need to obtain any necessary email communication from their Outlook email account prior to this date.  |
| **I have reviewed this form with the above named Professional Staff member and confirm that the change will not impact on the ability of the department to fulfill their clinical and academic deliverables and therefore support the request for change to move forward for recommendation by the City-Wide Credentials Committee and subsequently for approval by the Medical Advisory Committee and Boards of Directors of the London Health Sciences Centre and St. Joseph’s Health Care, London where applicable.** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****­­­­­­­­­­­­­­­­­­­­­­­­Signature of Professional Staff member / Please Print Name After Signature** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­****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****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date**  |