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: ____________________________________

TO: ____

(name of contact)

Contact Email: ____

Organization Name: ____

Organization's Address: ____

____

Telephone Number: ___________________ Fax Number: __________________

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

Date: ______________________________

Please return to:
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