`



**MULTI-APPOINTMENT CHANGE SUPPORT FORM**

This form is to be completed by the Department Chief to **request a change** to an existing clinical appointment for more than one Credentialed Professional Staff (Professional Staff) in their department. The department is expected to meet with each Professional Staff member to discuss the change in category. The Professional Staff member is required to sign the form in agreement and a copy placed in their credentialing file in Medical Affairs.

|  |
| --- |
| **Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Division: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Effective Date for Change: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Professional Staff Name** | **Professional Staff Signature** | **Primary Site** | **Secondary Site** | **Admitting Privileges** **Yes or No** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Comments:** |
| **I have reviewed this form with the above named Professional Staff member(s) and confirm that the change will not impact on the ability of the department to fulfill their clinical and academic deliverables therefore support the request for change(s) 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 Department Chief) (Date) |