SOIN/GREENE UNIFIED MEDICAL STAFF

(Indu & Raj Soin Medical Center/Kettering Health – Greene Memorial Hospital)

Advanced Practice Provider Request to Exercise Privileges at Additional Soin/Greene Location

Note:
This form is only for use by Advanced Practice Providers (APP) (*e.g.,* advanced practice registered nurses, physician assistants, *etc.*) who are currently granted and exercising clinical privileges at either Indu & Raj Soin Medical Center (Soin) or at Kettering Health - Greene Memorial Hospital (Greene); and who are requesting to exercise the same clinical privileges at the other Soin/Greene location at which the APP is not currently practicing.

Applicant Name: _____ Date Requested: _____

Current Assigned Department: _____

Current Clinical Privileges Granted: _____ **[Either specify the type of clinical privileges currently granted at Soin or Greene or attach a copy of your currrent approved Delineation of Privileges at Soin or Greene.]**

Name of APP's Collaborating or Supervising Practitioner(s)_____

Current Soin OR Greene Location Where Privileges Are Granted:

☐Indu & Raj Soin Medical Center

☐Kettering Health – Greene Memorial Hospital

Additional Soin OR Greene Location Where Privileges Are Requested:

☐Indu & Raj Soin Medical Center

☐Kettering Health – Greene Memorial Hospital

[Note: Applicant must provide an updated Delineation of Privileges (completed, dated, and signed) requesting the additional Soin/Greene location along with this form.]

Attestation:
I hereby attest that I have been granted the above stated clinical privileges which I am currently exercising at the above stated Soin or Greene location. I am requesting to exercise the clinical privileges specified in the attached Delineation of Privileges at the additional Soin or Greene location noted above.

I further attest that I am requesting only those clinical privileges for which, by licensure, education, training, experience, and demonstrated performance, I am qualified and clinically competent to perform. I agree to provide Soin/Greene with the information/documentation necessary to satisfy the qualifications set forth in the Advanced Practice Provider Policy and the applicable Delineation of Privileges for such clinical privileges. I understand that a grant of clinical privileges at an additional Soin/Greene location will be subject to a period of focused professional practice evaluation at such additional Soin/Greene location if such clinical privileges are granted.

Signature of Advanced Practice Provider:_____

Date:_____

Please submit to:
Medical Staff Services – Soin Medical Center/KH Greene Memorial
3535 Pentagon Blvd
Beavercreek, OH 45431
Phone: (937) 702-4033
Fax: (937) 702-4035