

**SOIN/GREENE UNIFIED MEDICAL STAFF**  
(Indu & Raj Soin Medical Center/Kettering Health – Greene Memorial Hospital)  
**Practitioner Request to Exercise Privileges at Additional Soin/Greene Location**

**Note:**

This form is only for use by Practitioners who are currently appointed to the Indu & Raj Soin Medical Center (Soin)/Kettering Health - Greene Memorial Hospital (Greene) Unified Medical Staff (UMS); who are currently granted and exercising clinical privileges at either Soin or at Greene; and who are requesting to exercise the same clinical privileges at the other Soin/Greene location at which the Practitioner is not currently practicing.

Applicant Name: \_\_\_\_\_ Date Requested: \_\_\_\_\_

Current UMS Appointment Category: \_\_\_\_\_

Current UMS Department: \_\_\_\_\_

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

**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 am appointed to the Soin/Greene UMS and 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 Medical Staff governing documents 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 Practitioner: \_\_\_\_\_

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