ADVANCED SURGICAL PRIVILEGES FORM / DERMATOLOGY

Applicant's Name: .....

License No. (If Any): ..... Date: D D M M Y Y Y Y

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Photo therapy	☐		☐	☐	
2. Melanocyte	☐		☐	☐	
3. Dermatopathology	☐		☐	☐	
4. Sclerotherapy	☐		☐	☐	
5. Microneedling	☐		☐	☐	

Additional privilege (not included above)

Privileges	For applicant use		For committee use				
	Request	Signature	Recommended			Not Recommended	Reason for rejection (if any)
			Facility type				
			Hospital	Day care	Clinic under LA		

Note:
You must submit along with this application all necessary document(s) to support your request.

Applicant's signature ..... Date: D D M M Y Y Y Y

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FOR COMMITTEE USE ONLY

Committee Decision:

Evaluation type:

- By Interview ☐ virtual / personal
- By documents only ☐
- Or both ☐

Other comments:

.....

We have reviewed the requested clinical privileges and supporting documentation for the above-named applicant, and We have made the above-noted recommendation(s).

Clinical privileging committee members:

.....
Name, Signature & Stamp

Date: DD MM YYYY

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Name, Signature & Stamp

Date: DD MM YYYY

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Name, Signature & Stamp

Date: DD MM YYYY

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