Request for Approval to Perform Surgical Privileges

To be filled by the Physician and the Medical Director of the facility where the applicant will perform the privileges

Date: _____ **License No.:** _____

Name: _____ **Scope of Practice:** _____

Required Documents:

1. A list of type and number of procedures performed by the surgeon within the last three years (logbook), signed and stamped by Chairperson of the department and Medical Director of the hospital(s) where the logbook has been issued attested from the embassy of country of origin and the Qatari Ministry of Foreign Affairs.
2. Full address of the hospital(s) where the logbook has been issued (including the name of the hospital, Fax No, Tel No., P.O. Box, Email, Website) for verification purpose.
3. For further requirements, please visit MOPH or DHP websites:
   http://www.moph.gov.qa/
   https://dhp.moph.gov.qa/

Undertaking:

I. The Physician:

I hereby declare that all information provided in this request and attached documents are accurate to the best of my knowledge. **I hereby undertake not to perform any procedure(s) before getting an official approval from the Registration Section/DHP**. I hereby undertake not to perform any procedure(s) not approved by the Registration Section/DHP; and that I shall bare all legal and disciplinary responsibilities in case of violation of this clause. Further, I declare that performing the approved procedures / treatments will be at my sole responsibility.

Signature: _____ **Stamp:** _____

II. The Facility: ***(The facility where the applicant will perform the privileges)***

This medical institution undertakes to provide all requirements that are legally and/or professionally deemed necessary for providing quality and safe care for patients before, during and after approved surgical intervention(s) are performed by this licensed and privileged surgeon in this facility. The institution also acknowledges taking full responsibility and financial liability in case of negligence and/or malpractice that have been proven beyond doubt which have directly or indirectly caused harm and/or complication(s) to the patient.

Institution: _____ **Stamp:** _____

Director: _____ **Signature and Stamp:** _____

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