Hartford Hospital
A Hartford HealthCare Partner

Medical Staff Office
Change in Delineation Form

Please choose what is applicable

REQUEST FOR ADDITION OR TO RELINQUISH PRIVILEGE(S) IN CURRENT DEPARTMENT

Practitioner Name: _____ **Date:** _____

Additional Privilege Request:
(PROVIDE PROOF OF COMPETENCY)
If delineation of privilege form needed, please contact the medical staff office.

Privilege(s) to be added:

_____
_____
_____

Request to Relinquish Privilege:

Privilege(s) to be relinquished:

_____
_____
_____

Current Department Name: _____

_____
Practitioner Signature **Date**

Request will be reviewed by the Chief, Credentials Committee, MEC and recommended for Board of Directors (BOD) approval. You will be notified of BOD's effective date.

REQUEST FOR PRIVILEGES IN AN ADDITIONAL DEPARTMENT **Date:** _____
Please request delineation of privilege form from the Medical Staff Office

Name of the Department you are requesting to also have privileges: _____

_____
Practitioner Signature **Date**

Request will be reviewed by the Chief, Credentials Committee, MEC and recommended for Board of Directors (BOD) approval. You will be notified of BOD's effective date.

FOR DEPARTMENT DIRECTOR: Name: _____

Do you approve the above request? Yes ☐ No ☐

Department Director Signature: _____ **Date:** _____

FOR MEDICAL STAFF OFFICE ONLY:

Medical Executive Committee Approval

☐ Approved ☐ Not Approved

Board of Directors Approval

☐ Approved ☐ Not Approved

Revised 2/17/16