مركز التخطيط والجودة للخدمات الطبية
CENTER FOR HEALTHCARE PLANNING & QUALITY

## Delineation of Clinical Privileges for Physician

**Name of applicant:**

**Name of operator:**

**Specialty of Practice:** (e.g. Dermatology, Orthopedics, etc.)

**Please provide a list of procedures that you will perform in your office/clinic or surgical day practice:** (Include any form of sedation/anesthesia, medical, surgical, & testing /diagnostic procedures). *This form can be duplicated as needed.*

**Applicant's Signature:**_____ **Date:**_____