



REQUEST FOR DELETION OF PRIVILEGE(S) FORM

Name _____ Specialty _____
(please print full name)

Please note that your request will be submitted to the Department Chair, Credentials Committee, Medical Board and Board of Trustees for action. In the event you wish to obtain these privileges in the future, you will need to reapply and must satisfy any required credentialing criteria in place at that time. You must explain the reason for your request. Please note that you may not delete privileges to avoid on-call responsibilities.

I am requesting to delete the following privileges:

Please describe in detail the basis for your request explaining your reason:

This request applies to privileges at the following facilities:

- | | |
|---|---|
| <input type="checkbox"/> Presbyterian Hospital Main/POH | <input type="checkbox"/> Presbyterian Hospital Matthews |
| <input type="checkbox"/> Presbyterian Hospital Huntersville | <input type="checkbox"/> South Park Surgery Center |
| <input type="checkbox"/> Ballantyne Surgery Center | <input type="checkbox"/> Monroe Surgery Center |

SIGNATURE: _____ **DATE:** _____

Fax form to (704) 316-9955 or mail to Jan Kelly at the following address:
Medical Staff Services • 200 Hawthorne Lane • Post Office Box 33549 • Charlotte, NC 28233-3549