

AFFILIATED PROFESSIONAL STAFF REAPPOINTMENT REVIEWS/APPROVALS

NAME: _____, **Affiliated Prof (P).** **Obstetrics & Gynecology**

*****If you do not recommend reappointment, a letter of explanation must accompany this packet.**

Affiliated Professional Recommendation: I have reviewed the attached reappointment application and request for standardized procedures/protocols. Based on my review of current licensure, **THE MOST RECENT PERFORMANCE APPRAISAL FROM DPH OR UCSF**, ongoing quality improvement activities, continuing education, clinical activity, professional liability experience, and OPPE, I find this provider able to perform the privileges and/or standardized procedures requested and recommend reappointment as an Affiliated Professional.

CLINICAL COMMENTS: _____

Division Chief	Date	Service Chief	Date
Committee on Interdisciplinary Practice:	Concur ___ NO		YES <u> √ </u>

COMMENTS: _____

	CIDP Committee Chair	Date:	
Credentials Committee:	Concur with Service Recommendation:	___ NO	YES <u> √ </u>

COMMENTS: _____

	Credentials Committee Chair	Date: 08/16/2019
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Medical Executive Committee:	Concur with Service Recommendation:	NO ___	YES <u> √ </u>
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COMMENTS: _____

	Chief of Staff	Date: 08/16/2019
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Action by Governing Body:	Concur with Medical Staff Recommendations	___ NO	YES <u> √ </u>
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Executive Administrator	Date: 08/16/2019	Director of Health	Date: 08/16/2019
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