

FACILITIES LIST

The Board requires a list of all facilities where you have had medical privileges during the last 10 years. List any facility where you are getting (have been) paid outside of a postgraduate training program. If you have had no privileges, write **NONE** and sign and date the form.

CURRENT PRIVILEGES

<u>Facility</u>	<u>City and State</u>	<u>Type of Privilege</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST PRIVILEGES (LAST 10 YEARS)

<u>Facility</u>	<u>City and State</u>	<u>Type of Privilege</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify that the above is a true and accurate list of inpatient and outpatient facilities at which I have (have had) medical privileges.

Print Name _____

Signature _____ Date _____