

**North Oaks Medical Center
Request for Temporary Medical Staff Privileges
Practitioner-in-Training**

Physician Name: Last	First	Middle
Office Address:		
City/State/Zip		Phone
Beeper and/or Answering Service #(s):		
Home Address:		
City/State/Zip		Phone
Social Security #	Date of Birth:	Louisiana Medical License #
DEA #	CDS #:	
Medical School		Year of Graduation
Scope of Privileges Requested <input type="checkbox"/> Practitioner-in-Training Dates Requested: ____/____/____ thru ____/____/____		
I hereby certify that the above information is true and that to the best of my knowledge my general health is good. I have reviewed the Medical Staff bylaws, rules & regulations and agree to be bound by the terms thereof in all matters relating to temporary clinical privileges.		
Signature of Applicant		Date

APPROVALS:

Department Chairman; OR

Chief of Staff

Robert Peltier, MD
Chief Medical Officer

Michele Sutton, FACHE
President/CEO