REQUEST FOR RESIGNATION

Individual requesting this leave of absence should refer to the Medical Staff Bylaws, Section 2.13 for further information. This completed form should be returned by email to the Credentials and Qualifications Department at credentials@browardhealth.org, or alternatively, faxed to 954-473-7255. The request will be reviewed and acted upon, and you will receive notification in a timely manner.

Name:
Department:
Specialty:

Facility(ies) For Request ___________________________________

I hereby request a voluntary resignation and relinquishment of clinical privileges from Broward Health Hospitals as listed below. I understand that for this request to be approved, I must be in good standing, or if this action is requested during the course of an investigation regarding improper conduct or incompetence, a report will be submitted to the state professional licensing board for reporting to the National Practitioner Databank, as required by state and federal law. Further, I understand that I am required to complete any incomplete medical records, return the hospital ID badge, keys, parking gate openers, and any other hospital property to the facility which issued them to me, and that I may not provide any patient care or otherwise exercise any clinical privileges upon approval of this request.

Date of Request:	/ /	Desired Effective Date:	/ /
Reason for Request:	☐ Relocation ☐ Practice Change ☐ Contract Change ☐ Support Services ☐ Equipment Availability ☐ Dissatisfaction (explain) ☐ Other (explain) _______________________________________		
Are you aware of any pending investigation as described above?	☐ Yes ☐ No If yes, provide details: _______________________________________ _______________________________________		
Current Appointment Term for the Facility(ies) Where Resigning	Initial Privilege Date: Privilege Expiration Date: Privilege Status: Staff Category:		
Primary Facility:			
Other Affiliations:	☐ Broward Health Coral Springs ☐ Broward Health Medical Center ☐ Broward Health North ☐ Broward Health Imperial Point ☐ Community Health Services, Site(s): _______________________________________		
AHP/Physician Sponsorships:			
Contact Information: ***Must provide if different than current info***	Notification of action will be provided to you upon approval.		
Must provide hand-written signature			

Notes or Conditions from Facility:	
Approvals: *(documented in meeting minutes)*	☐ Credentials and Qualifications Committee Date: ____________________ ☐ Medical Council Date: ____________________ ☐ Board Date: ____________________

☐ MSO notified CQD of action
☐ MSO notified practitioner of action
☐ CQD updated action in database