FLEMING COUNTY HOSPITAL
REQUEST FOR TEMPORARY PRIVILEGES
PHYSICIAN SUPERVISED STUDENTS

_____ _____
Student Name Course of Study

_____
Student Address City State Zip Code

(_____) _____-_____ _____/_____/_____ _____-_____-_____
Student Phone Number Date of Birth Social Security Number

_____ _____
Teaching Facility Physician Sponsor

_____
Duties while at Fleming County Hospital

_____

_____

_____

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Please attach a copy of your medical liability face sheet and copy of current license (if applicable)

Do you have any physical, mental or emotional conditions that could affect the exercise of your clinical privileges, your provision of quality, safe, patient care, or which might limit your ability to meet other duties associated with staff privileges and which could require an accommodation for you to exercise your clinical privileges and staff duties completely and safely? ☐ Yes ☐ No

If yes, explain _____

_____

_____

_____ _____/_____/_____
Student Signature Date

I hereby consent to serve as a "Sponsoring Physician" for the above mentioned applicant for a period of _____ day's effective _____. This applicant will be under my direct supervision while at Fleming County Hospital.

_____, MD/DO _____/_____/_____
Sponsoring Physician Signature Date