Request for approval to perform Surgical Privileges
For Consultant / Specialist Physicians

Date: _____
Name: _____ **License No.:** _____
Scope of practice: _____

Required Documents:

1-A list of type and number of procedures performed by the Surgeon within the last three years (log book) Signed and Stamped by chairperson of the Dept and Medical Director of the Hospital (s) where the Log Book has been issued attested from Embassy of country of origin + Qatari Ministry of Foreign affairs .
2- Full Address of the Hospital (s) where the Log Book has been issued (including the name of the hospital, Fax No, Tel No. , P.O. Box, Email, Website) for verification purpose.
3-For further requirements, please visit MOPH or QCHP websites: http://www.moph.gov.qa/ , http://www.qchp.org.qa/

Kindly note that you must submit all the required documents otherwise your request will be neglected.

Undertaking:

I. The Physician:
I hereby declare that all information provided in this request and attached documents are accurate to the best of my knowledge.
I hereby undertake not to perform any procedure(s) before getting an official approval from the Registration Department/ QCHP.
I hereby undertake not to perform any procedure(s) not approved by the Registration Department/ QCHP; and that I shall bare all legal and disciplinary responsibilities in case of violation of this clause. Further, I declare that performing the approved procedures / treatments will be at my sole responsibility.

Signature: _____ **Stamp:** _____

II. The Facility:
This medical institution undertakes to provide all requirements that are legally and/or professionally deemed necessary for providing quality and safe care for patients before, during and after approved surgical intervention (s) are performed by this licensed and privileged Surgeon in this facility. The institution also acknowledges taking full responsibility and financial liability in case of negligence and/or malpractice that have been proven beyond doubt which have directly or indirectly caused harm and/or complication(s) to the patient.

Institution: _____ **Stamp:** _____

Director: _____ **Signature:** _____ **Stamp:** _____