FAITH, HOPE AND LOVE

HOPE STREET FREE CLINIC
FAITH, HOPE AND LOVE

DECLARATION OF HEALTH

To be completed by the applicant

I hereby declare that, to the best of my knowledge, I do not have any physical or mental health condition or ailment that in any way impairs or limits, or might impair or limit, my ability to safely and skillfully carry out the clinical privileges which I have requested from Hope Street Free clinic.

_____

Printed Name

_____ _____

Signature Date

Applicant: Please forward to your physician for confirmation of your health declaration.

CONFIRMATION OF APPLICANT'S DECLARATION

To be completed by the applicant's physician

To the best of my knowledge, I concur with the declaration for the ability to perform the privileges requested by the applicant listed above.

_____

Printed Name of Confirming Physician

_____ _____

Address of Confirming Physician Phone Number

_____ _____

Signature of Confirming Physician Date

Please return by Fax to 980-734-3802 or email credentials@hopestreetfreeclinic.org