FLOYD CHEROKEE MEDICAL CENTER
SPP Functions Requested

_____ _____
Name in Full **Supervising Physician**

_____ _____
Title **Department**

Please list detailed description of each activity to be performed and note the degree of supervision, *direct or indirect*, by each.

Functions	Direct	Indirect	Approved

Date _____ _____
Signature of Applicant

Date _____ _____
Signature of Supervising Physician

APPROVED FCMC:

_____ _____
President, Medical Staff Date

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

_____ Concur with Credential Committee's recommendation and forward to governing body

_____ Return to Credentials Committee for clarification of the following:

_____

_____Date

BOARD APPROVAL _____*Yes* _____*No* _____ *Date*

03.24.20