FLOYD 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 FMC:

______________________________ ____________________
Department Chairman or Director Date

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION ____________________
Date

_______ Concur with Department's recommendation and forward to governing body

_______ Return to Department for clarification of the following: ______________

BOARD APPROVAL; ______ *YES* ______ *NO* ____________________
Date

10.18.17