



Medical Staff Office
Relinquishment of Privileges Form for Medical Staff

Provider's Name: _____

Relinquishment of Appointment & Privileges at Deaconess Gibson Hospital

Reason (check one):

- | | |
|--------------------------------------|----------------------------|
| <input type="checkbox"/> Resignation | Date of Resignation: _____ |
| <input type="checkbox"/> Termination | Date of Termination: _____ |
| <input type="checkbox"/> Retired | Date of Retirement: _____ |

Comments (optional):

Signature: _____

Date: _____

Printed or Typed Name and Title: _____

(Provider, Office Manager, Practice Manager, or Other Applicable Individual)