



**TO BE COMPLETED BY APPLICANT:**

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges will not proceed until which time that the information is received.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY SPONSORING PHYSICIAN:**

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

\_\_\_\_\_  
Sponsoring Physician's Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL:**

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

\_\_\_\_\_  
Regions Division/Section Head Signature

\_\_\_\_\_  
Date