UW Medicine - Northwest Hospital & Medical Center
Seattle, Washington

Registered Health Professional Supplement to Washington Practitioner Application

MEDICAL STAFF SPONSORSHIP

Requirements for Registered Health Professional (RHP) Staff membership include submitting a letter of sponsorship from a member of the Northwest Hospital Active Medical Staff. In addition, you are required to submit a signed Sponsorship Agreement for each physician you will assist (either as a surgical or medical RHP). Please list below your Active Staff Sponsor and any NWH Medical Staff members you will assist.

Active NWH Medical Staff sponsor: _____

Other NWH Medical Staff Affiliations: _____

ACKNOWLEDGMENTS AND AGREEMENTS

Your signature below certifies your acknowledgment of and agreement to the following:

a. Continuing Obligation to Report
You will fully report all relevant information to Northwest Hospital as soon as practical in the event any of the events indicated in questions A 1 through D 5 on page 11 of the Washington Practitioner Application (i.e., if one of those questions must be answered "yes") after you have signed and dated this form while your application is pending and, if you are granted privileges at this Hospital, while you have privileges here.

b. You recognize that your appointment to the Registered Health Professional Staff of this Hospital and the granting of clinical privileges to you is dependent on professional competence and ethical practice in keeping with the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules and Regulations.

c. Additional Conditions of Continuing Medical Staff Membership and Clinic Privileges

You agree to maintain an ethical practice, to provide for continuous care of all your patients, and to abide by the Medical Staff Bylaws and Rules and Regulations of Northwest Hospital, and all laws, rules and regulations of applicable governmental entities.

YOU FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENTS IN OR OMISSIONS FROM THIS APPLICATION WILL CONSTITUTE CAUSE FOR DENIAL OF YOUR APPLICATION FOR APPOINTMENT, AND TERMINATION OF MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES. YOU HEREBY AFFIRM THAT THE INFORMATION FURNISHED BY YOU TO THE MEDICAL STAFF IS TRUE AND COMPLETE TO THE BEST OF YOUR KNOWLEDGE.

_____ _____

Signature Date

_____

Name (Print or Type)