

**Request for approval to perform Surgical Privileges
For Consultant Surgeons**

Date : _____
Name : _____ **License No.:** _____
Professional Title: _____

Required Documents:

1-A list of type and number of procedures performed by the Surgeon within the last three years (log book) Signed and Stamped by chairperson of the Dept and Medical Director of the Hospital (s) were the Log Book has been issued attested from Embassy of country of origin + Qatari Ministry of Foreign affaires .

2- Full Address of the Hospital (s) were the Log Book has been issued (including the name of the hospital , Fax No , Tel No. , P.O.Box , E.mail , Web Site) for Verification purpose .

kindly note that you must submit all the required documents other wise your request will be neglected .

Undertaking:

I. The Consultant :

I hereby declare that all information provided in this request and attached documents are accurate to the best of my knowledge.

I hereby undertake not to perform any procedure(s) not approved by the Department of Medical Licensing; and that I shall bare all legal and disciplinary responsibilities in case of violation of this clause. Further, I declare that performing the approved procedures / treatments will be at my sole responsibility.

Signature: _____ Stamp: _____

II. The Facility: this medical institution undertakes to provide all requirements that are legally and/or professionally deemed necessary for providing quality and safe care for patients before, during and after approved surgical intervention (s) are performed by this licensed and privileged Surgeon in this facility. The institution also acknowledges to take full responsibility and financial liability in case of negligence and/or malpractice that have been proven beyond doubt which have directly or indirectly caused harm and/or complication(s) to the patient.

Institution: _____ Stamp: _____

Director : _____ Signature: _____ Stamp: _____

Request for approval to perform Surgical Privileges
For Specialist Surgeons

Date : _____
Name : _____ **License No.:** _____
Professional Title: _____

Required Documents:

1-A list of type and number of procedures performed by the Surgeon within the last three years (log book) Signed and Stamped by chairperson of the Dept and Medical Director of the Hospital (s) were the Log Book has been issued attested from Embassy of country of origin + Qatari Ministry of Foreign affairs .

2- Full Address of the Hospital (s) were the Log Book has been issued (including the name of the hospital , Fax No , Tel No. , P.O.Box , E.mail , Web Site) for Verification purpose .

Undertaking:

I. The Specialist :

I hereby declare that all information provided in this application and attached documents are accurate to the best of my knowledge.

I hereby undertake not to perform any procedure(s) not approved by the Department of Medical Licensing; and that I shall bare all legal and disciplinary responsibilities in case of violation of this clause. Further, I declare that performing the approved procedures/treatments will be at my sole responsibility.

ملاحظة : يتعهد الأخصائي بان يجري كافة العمليات المذكورة أفنا تحت إشراف الاستشاري المذكور .

Signature: _____ Stamp: _____

II. The Consultant : I hereby undertake not to perform any procedure(s) not approved by the Department of Medical Licensing; and that I shall bare all legal and disciplinary responsibilities in case of violation of this clause. Further, I declare that performing the approved procedures/treatments will be at my sole responsibility.

ملاحظة مهمة : هنا يجب أن يتعهد الاستشاري بأنه سيقوم بالإشراف الكامل على العملية وان تكون هذه العملية من ضمن الامتيازات التي منحت له وان يتحمل المسؤولية كاملة في حال حصول مضاعفات طبية .

Name : _____ Signature: _____ Stamp: _____

III. The Facility: this medical institution undertakes to provide all requirements that are legally and/or professionally deemed necessary for providing quality and safe care for patients before, during and after approved surgical intervention (s) are performed by this licensed and privileged Surgeon in this facility. The institution also acknowledges to take full responsibility and financial liability in case of negligence and/or malpractice that have been proven beyond doubt which have directly or indirectly caused harm and/or complication(s) to the patient.

Institution: _____ Stamp: _____

Director : _____ Signature: _____ Stamp: _____