



**Letter of Intent for Application for Privileges**  
for Assessment of Practitioner Health at Tahoe Forest Hospital System

Please print clearly and complete **ALL** blanks:

Practitioner Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Mailing Address for Confidential Information: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

In planning for the next 2 years, I am applying or reapplying for clinical privileges with the following work schedule:  
Percentage of my work (clinical, service, non-clinical) at TFH/IVCH: \_\_\_\_\_

**Inpatient:**

- Hospitals/duties: \_\_\_\_\_
- Shift duration, timing, frequency, numbers of patients \_\_\_\_\_
- Additional time spent on work, including charting after hours or other administrative duties: \_\_\_\_\_
- \_\_\_\_\_ percent of work at TFH/IVCH that is inpatient care.

**Outpatient:**

- Location/Clinic(s) \_\_\_\_\_
- Shift duration, timing, frequency, numbers of patients \_\_\_\_\_
- Additional time spent on work, including charting after hours or other admin duties: \_\_\_\_\_
- \_\_\_\_\_ percent of work at TFH/IVCH that is outpatient care.

**Other:**

- I plan to serve in the role of (please circle): Researcher / Medical Advisor / Committee work / Consultant / Teaching / Other \_\_\_\_\_
- \_\_\_\_\_ Percentage of time in these roles

Additional Work Outside TFH/IVCH: Describe any additional work you plan to be doing in the next 2 years.

Considering all of the outlined above work at TFH/IVCH, compensated and not, I plan to work the following:

Days per week: \_\_\_\_\_ or Days per month: \_\_\_\_\_ Hours per shift: \_\_\_\_\_

Evenings per month: \_\_\_\_\_ Swing/nights per month: \_\_\_\_\_

I plan to take day / night call: \_\_\_\_ Yes \_\_\_\_ No. If Yes: \_\_\_\_ times per month and at these facilities:

Feel free to attach additional description of what your ideal work arrangement would be in the next 2 years.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I am physically, emotionally, and mentally fit for the practice of medicine outlined above. I understand that the Chief of Staff and the Chief Medical Officer will be reviewing the results of this assessment and any additional testing and will help determine in conversations with me if any concerns are raised, or if accommodations will need to be recommended. I understand that if I do not complete these evaluations or further requested evaluations in the time-frame outlined, my application for initial appointment or reappointment will be considered withdrawn.

I have read and understand the Late Career Physician Policy. I will complete the requirements within the required time-frame. I understand that I have the option to meet with the Well-Being Committee as a confidential advocate throughout this process.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** This Letter of Intent should be returned to the Director of Medical Staff Services, by fax, email or U.S. Mail. Fax is 530-582-6660. E-Mail is: [medstaff@tfhd.com](mailto:medstaff@tfhd.com). Address is Tahoe Forest Hospital Medical Staff Services office, 10121 Pine Ave., Truckee, CA 96161. Phone is 530-582-6640. **Thank you.**