



**VOLUNTARY RESIGNATION OF MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES:
DOLLY CHILDREN'S PHYSICIANS**

Name: _____ **Credentials:** _____

Department/Specialty: _____

Today's Date: _____ **Date Privileges Should Terminate:** _____

Forwarding Contact Information:

Address: _____

Phone: _____ Email: _____

If you are responsible for providing supervision for any Allied Health Professionals, please list below:

Name/Credentials: _____ Name/Credentials: _____

Name/Credentials: _____ Name/Credentials: _____

Name/Credentials: _____ Name/Credentials: _____

By signing this form, I hereby voluntarily resign my membership on the Medical Staff of Dolly Parton Children's Hospital ("Dolly Children's") and relinquish all clinical privileges granted to me. My privileges at Dolly Children's shall expire on the date provided above ("Date Privileges Should Terminate").

I affirm that this resignation is submitted voluntarily and is not made in lieu of, or during the pendency of, an investigation, corrective action, or disciplinary proceeding.

Additionally, by signing this form, I agree to:

- Complete all outstanding medical records in accordance with hospital policy
- Cooperate in the safe transition of care for any active patients
- Return hospital property and comply with information security requirements
- Abide by continuing obligations under the Medical Staff Bylaws and hospital policies

Signature: _____

Please scan and email this completed form to etchcred@etch.com