BWH Provider Services
Declaration of Health

Please be sure to have a provider of your choice complete the bottom half of this form before returning it to BWH Provider Services. The provider must not be a family member and must be either your PCP or a provider who is able to attest to your health and physical competence to practice as a clinical provider.

DECLARATION OF HEALTH

I, ______________________________, hereby declare that, to the best of my knowledge, I do not have a physical or mental health condition that would adversely affect my ability to carry out the clinical privileges which I have requested from the Brigham and Women’s Hospital and/or Brigham and Women’s Faulkner Hospital, Boston, Massachusetts.

____________________________________                          ________________________
Signature       Date

CONFIRMATION OF APPLICANT’S DECLARATION

I concur with the declaration of health* presented by ______________________________
(Applicant)

________________________________________                 _________________________
Provider Signature       Date

________________________________________
Print name

* The applicant’s health status must be evaluated in terms of his or her ability to practice in the area in which clinical privileges are being requested.