EP 6.17-A
Request for New Clinic Procedures Approval Form
To be completed by requesting physician

Name of requesting physician:_____________________________________________________

Requested Procedure: _____________________________________________________________

Department/Clinic: _______________________________________________________________

Description: Describe the procedure or treatment, including the indications and contraindications
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Equipment: List any new equipment required or indicate “Not Applicable”
________________________________________________________________________________

Additional Resources: List additional resources required or indicate “Not Applicable”
________________________________________________________________________________

Staff Training: List any training needed for clinic staff
________________________________________________________________________________

Date procedure/service is to be implemented: ______________________________________

Requestors Signatures:

Physician:______________________________ Date:______________________________

Medical Director/Chair: ____________________________ Date________________________

Department Administrator: ________________________________ Date_________________

Approvers Signatures:

Director of Nurses: ____________________________ Date__________________________

Office of Claims Management: ________________________________ Date________________

Office of Medical Staff: ________________________________ Date____________________

Office of Quality Improvement: ____________________________ Date:________________