Dear Provider,

As part of Gracepoint's initial and biannual credentialing / privileging process, we confirm the health fitness status of all providers. Please answer the following question and then return this letter / form to HR. This letter is confidential and will become part of your credentialing file.

Thank you,
Management Team

I do not have any physical or mental health condition(s) that will affect my ability to fulfill all the functions and obligations of my current privileges and job description at Gracepoint.

Agree☐ Disagree☐

If you disagree to the above question, please provide full details.

I hereby certify that the above information is complete and that it fairly and accurately discloses all matters requested.

Practitioner Signature_____ Date _____

Medical Director Signature_____ Date _____

Director of Nursing Signature_____ Date _____

Chief Operating Officer Signature_____ Date _____