Maternity Care for BC (MC4BC) Facility Letter of Support

The purpose of this form is to confirm that the MC4BC applicant has permission to complete the MC4BC Program at their selected facility.

This form should be signed by the Health Authority-approved physician leader who is responsible for recommending/confirming hospital obstetrical privileges (e.g., Chief of Medical Staff, Department Head, Division Head etc.).

To be completed by MC4BC applicant:

MC4BC Applicant Full Name		
Facility Name		
Preceptor Name(s)		
Brief description of learning activities		
Planned dates for learning	**Start Date**	**End Date**

To be completed by Facility:

Please confirm the following statements by checking the box:

☐ I confirm that I support the MC4BC applicant's self-directed learning plan at this facility.

☐ I confirm that the MC4BC applicant has met the requirements and has been (or will be) granted temporary hospital privileges to provide obstetrical care during the identified learning dates.

Full Name, Title	
Signature	
Date	