

DATE: _____

TO: Haylie Johnson
 Perioperative Services Administrative Assistant

FROM: _____
 Surgeon or Group Name (PRINT FIRST AND LAST NAME) Contact Name and Number: _____

1. Check One:

I currently do not have block time and am requesting the following block:

I am requesting additional surgical block time:

I am requesting that the following block time be canceled:

2. Choose Day of Week, Frequency and Time:

Day of week	Frequency	Time of day
Monday	1 st and 3 rd	0730-1730 M-Th 0830-1730 F
Tuesday	2 nd and 4 th	
Wednesday	Every	
Thursday	1 day/month	
Friday		

3. Return completed form to:

Haylie Johnson
 Perioperative Services
 Administrative Assistant
 2500 NE Neff Road
 St. Charles Medical Center
 Bend, OR 97701

OR: FAX TO:

541.706.6369
 Attn: Haylie Johnson

OR: EMAIL TO:

cmscanlon@stcharleshealthcare.org

Comments _____

2017 Block Oversight Committee Meeting Calendar		
2017 Meeting Dates	Requests due from Surgeon	Notification of Decision to Surgeon by
Thursday, January 19	Monday, January 16	Friday, January 27
Thursday, February 16	Monday, February 13	Friday, February 24
Thursday, March 16	Monday, March 13	Friday, March 24
Changed to Quarterly Meeting Schedule		
Thursday, April 20	Monday, April 17	Friday, April 28
Thursday, July 20	Monday, July 17	Friday, July 28
Thursday, October 19	Monday, October 16	Friday, October 27