PMS
PRESBYTERIAN MEDICAL SERVICES
Building a Healthier State

PRESBYTERIAN MEDICAL SERVICES
REQUEST FOR CLINICAL PRIVILEGES – MEDICAL

Applicant Name: ______________________________ **Date:** ______________

Specialty: ______________________________

Facility: ______________________________

CATEGORIES OF PRIVILEGES: NPs, PAs, CNSs

Category 1: (New Provider; Limited Experience)

Illnesses or problems with no serious threat to life, except for emergencies. When doubt exists as to the diagnosis or in cases where improvement is not soon apparent, consultation must be obtained.

Category 2: (Experienced Provider)

Complex illnesses or problems requiring skills acquired through additional medical training and/or as a consequence of clinical experience. Consultation must be obtained when the patient is seriously or critically ill and the diagnosis is in doubt, or improvement is not soon apparent except in irreversible or terminal illness.

CATEGORIES OF PRIVILEGES: MDs, DOs

Category 1: (New Provider, not Board Certified)

Complex illnesses or problems with no serous threat to life, except for emergencies. Consultation must be obtained when the patient is seriously or critically ill and the diagnosis is in doubt, or improvement is not soon apparent except in irreversible or terminal illness.

Category 2: (Experienced Provider, Board Certified)

Complex or severe illnesses or problems and those with immediate threat to life requiring skills as a consequence of clinical experience. Providers in this category may act as consultants to others and in turn should request consultation when diagnosis or management is in doubt or when subspecialty skills are needed.

Privileges

I am qualified and request the following privileges (please check level in which you are primarily engaged):

Specialty/Subspecialty Area(s)	Category 1	Category 2
Family Practice	☐	☐
Pediatrics (Pediatricians only)	☐	☐
Internal Medicine (Internists only)	☐	☐
Women's Health	☐	☐
Psychiatry (Psychiatrists only)	☐	☐
Optometry	☐	☐
Podiatry	☐	☐
Telemedicine	☐	
Palliative Care (PMS Hospice only)	☐	

Specialty Procedures (as supported by facility)

Please check all that apply:

☐ **Colposcopy**	☐ **Sigmoidoscopy**	☐ **Norplant Insertion**	☐ **Vasectomy**
☐ **IUD Insertion**	☐ **Office Obstetric Care**	☐ **Newborn Circumcision**	

Applicant Attestation:

I hereby certify that the documentation and information contained or attached to this application is true and complete to the best of my knowledge. I realize that misstatement or omission may result in denial of this application. I affirm that, if granted the requested privileges, I will provide services in accordance with the established standards, protocols, policies and procedures of Presbyterian Medical Services. I also affirm that I will practice only within the scope of privileges granted, and will do so in keeping with the established professional ethics guidelines of my professional discipline.

______________________________ ______________

Applicant's Signature **Date**

______________________________ ______________

Medical Director's Signature Indicating Approval **Date**