



Delineation of Privileges

DERMATOLOGY SERVICE

NAME _____

Documentation of training and experience must accompany the original application for privileges or any request for additional privileges.

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|---------------------------------|-------------------------------|
| Privileges Requested | Privileges Granted |
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| _____ | _____ |
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DERMATOLOGY GENERAL PRIVILEGES

Privileges approved for Internal medicine which are applicable to the laboratory diagnosis and medical management of patients with skin diseases.

CUTANEOUS SURGERY

A. LOCAL ANESTHESIA

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| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Excision of Benign and Malignant Lesions
 Skin Biopsy
 Local Skin Flaps and Split and Full Thickness Skin Grafts as may be necessary to close Surgical Defects
 Curettage and Electrodesiccation
 MOHS surgery
 Hair Transplant

B. GENERAL ANESTHESIA

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Excision of Benign and Malignant Lesions
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RADIOLOGY AND RADIOTHERAPY

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| _____ | _____ |
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Superficial Radiation Therapy

ALLERGY AND IMMUNOLOGY

Skin Patch Testing
Photo Patch Testing
Intradermal Skin Testing
Indirect Immunofluorescence of Skin
Direct Immunofluorescence of Skin

PHYSICAL THERAPY

Hot Quartz Lamp
Cold Quartz Lamp
Solar Simulator
Fluorescent Tube Light Box
Use of Equipment of Calibrate Above

MISCELLANEOUS

Epilation
Tzanck Cytology
Crush Preparation Cytology
KOH and Culture for Fungus
Scotch Tape Stripping of Skin
Intralesional Therapy
Darkfield Examination
Gram Stains
Topical and Intralesional Chemotherapy for Benign and Malignant Lesions of the Skin

Admitting Privileges

Requested _____ Granted _____

Signature of Applicant

Date

Requested Privileges: Approved as Indicated _____ Denied _____
*If denied, please provide explanation on separate sheet

Signature of Service Chief

Date



HEALTH STATEMENT

TO CHIEF OF SERVICE / CHIEF OF STAFF

1. I HEREBY CERTIFY THAT I POSSESS THE NECESSARY COGNITIVE AND MOTOR SKILLS TO SAFELY PERFORM ALL PRIVILEGES REQUESTED AND DECLARE MYSELF TO BE FREE FROM ANY CONDITION, ILLNESS, OR INFECTIOUS DISEASE THAT COULD COMPROMISE PATIENT CARE OR MY ABILITY TO PERFORM THE PRIVILEGES REQUESTED.

YES NO

2. IF NO, DO YOU HAVE A PHYSICAL OR MENTAL CONDITION OR ILLNESS (INCLUDING ANY CHEMICAL OR ALCOHOL DEPENDENCY) WHICH COULD AFFECT YOUR ABILITY TO EXERCISE THE CLINICAL PRIVILEGES REQUESTED WITHOUT SPECIAL ACCOMMODATIONS IN ORDER FOR YOU TO EXERCISE THE PRIVILEGES REQUESTED SAFELY AND COMPETENTLY? TO ANSWER THIS QUESTION APPROPRIATELY, PLEASE REPORT ANY CONDITION WHICH IS, OR MAY BE INFECTIOUS, COULD AFFECT MOTOR SKILLS, COGNITIVE ABILITY OR JUDGMENT, OR COULD POTENTIALLY ADVERSELY AFFECT YOUR ABILITY TO CARE FOR PATIENTS OR TO INTERACT APPROPRIATELY WITH OTHER CAREGIVERS.

YES NO

If yes, please explain:

3. HAVE YOU TESTED POSITIVE FOR THE TUBERCULIN SKIN TEST? YES NO
If yes, please give date of positive skin test. _____
If no, when was your last PPD test? _____

REGARDLESS OF HOW THIS QUESTION IS ANSWERED, THE APPLICATION WILL BE PROCESSED IN THE USUAL AND CUSTOMARY MANNER. IF YOU HAVE ANSWERED THIS QUESTION AFFIRMATIVELY AND ARE FOUND TO BE PROFESSIONALLY QUALIFIED FOR MEDICAL STAFF APPOINTMENT AND CLINICALLY COMPETENT TO PERFORM THE CLINICAL PRIVILEGES REQUESTED, YOU WILL BE GIVEN AN OPPORTUNITY TO MEET WITH THE EXECUTIVE COMMITTEE TO DETERMINE WHAT ACCOMMODATIONS, IF ANY, ARE NECESSARY TO ALLOW YOU TO PRACTICE SAFELY.

SIGNATURE OF APPLICANT

DATE

CHIEF OF SERVICE

DATE