



## Core Privileges

### HEMATOLOGY & MEDICAL ONCOLOGY SERVICES

**Medical Oncologists** are internists who specialize in the diagnosis and treatment of all types of cancer and other benign and malignant tumors. Those who hold privileges in Medical Oncology decide on and administer therapy for these malignancies, and consult with surgeons and radiotherapists on other treatments of cancer.

**Hematologists** have additional training and specialize in diseases of the blood, spleen, and lymph, and treat conditions such as anemia, clotting disorders, sickle cell disease, hemophilia, leukemia, and lymphoma.

**QUALIFICATIONS:**

- MD or DO with successful completion of an ACGME or AOA-accredited fellowship training program in oncology and/or hematology
- Current certification or active participation in the examination process leading to certification in hematology or medical oncology by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.
- Documentation or attestation of the management of hematologic and/or oncologic problems for at least 50 inpatients or outpatients as the attending physician during the past two years.

(R)= Recommended as Requested (A)=Approved as Requested (C)=Recommended with Condition(s) (N)=Not Recommended

Requested						
Yes	No	<b>CORE PRIVILEGES</b>	(R)	(A)	(N)	(C) Condition/Reason(s)
		<p><b>Medical Oncology:</b> Privileges to admit, evaluate, diagnose, consult, and provide treatment or consultative services to patients of all ages presenting with cancer and other benign and malignant tumors.</p> <p>Additional core privileges include:</p> <ul style="list-style-type: none"> <li>❖ Bone marrow aspirations and biopsy</li> <li>❖ Incisional and excisional skin biopsy</li> <li>❖ Administration of chemotherapy agents and biological response modifiers through all therapeutic routes</li> <li>❖ Management and maintenance of indwelling venous access catheters</li> <li>❖ Lumbar puncture</li> </ul> <p><i>[You may mark through any privilege you will not be doing at/for this facility and do not wish to request]</i></p>				
		<p><b>Hematology:</b> Privileges to admit, evaluate, diagnose, and provide treatment or consultative services to patients of all ages with illnesses and disorders of the blood, blood-forming tissues, and immunologic system.</p> <p>In addition to the above core privileges in medical oncology, the following are included in hematology core privileges:</p> <ul style="list-style-type: none"> <li>❖ plasmapheresis</li> <li>❖ lymph node aspirations</li> <li>❖ arthrocentesis, large joint</li> <li>❖ therapeutic thoracentesis and paracentesis</li> </ul>				

I attest to managing hematologic and/or oncologic problems of at least 50 patients as the attending physician during the past two years and have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Teche Regional Medical Center.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommended the privileges as indicated above.**

\_\_\_\_\_  
Signature of Service or Department Chair

\_\_\_\_\_  
Date

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**Board of Trustees' Decision**

*Teche Regional Medical Center's Board of Trustees*

**Does**

**Does not grant clinical privileges as requested**

(if "does not" grant, give reasons in letter to the applicant with a copy of privilege list)

\_\_\_\_\_  
Secretary, Board of Trustees

\_\_\_\_\_  
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:

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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