



Core Privileges

NEPHROLOGY SERVICE

QUALIFICATIONS:

- MD or DO with successful completion of an ACGME or AOA-accredited residency/fellowship training program in Nephrology;
- Current certification in Internal Medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine;
- Board eligible or board certified in Nephrology by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or equivalent credentials as determined by the Service Chief;
- Documentation or attestation of the performance of at least 100 nephrology procedures and/or care of 100 patients with renal disease in the past two years.

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

Requested						
Yes	No	CORE PRIVILEGES	(R)	(A)	(N)	(C) Condition/Reason(s)
		Privileges to admit, evaluate, diagnose, and provide treatment or consultative services to all patients, of all ages, presenting with illnesses, injuries, and disorders of the kidneys. Core Privileges also include: <ul style="list-style-type: none"> <input type="checkbox"/> Acute and chronic hemodialysis <input type="checkbox"/> Placement of temporary vascular access for hemodialysis and related procedures <input type="checkbox"/> Peritoneal dialysis (excluding placement of peritoneal dialysis catheters) <input type="checkbox"/> Continuous renal replacement therapy <input type="checkbox"/> Catheter insertion <input type="checkbox"/> Percutaneous renal biopsy <input type="checkbox"/> Renal clearance studies <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>				

I attest to the performance of at least 100 nephrology procedures and/or care of 100 patients with renal disease in 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.

I am further requesting membership to the: Active Courtesy Consulting Staff

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

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:

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