Core Privileges

PATHOLOGY SERIVCE

Qualifications: MD or DO with successful completion of an ACGME accredited training program in anatomic pathology and clinical pathology (APCP) and board certification by the American Board of Pathology (ABP) or board qualified. All certificates granted by the ABP during or after January 2006 are time limited for 10 years. The practitioner seeking renewal of privileges must be engaged in ABP maintenance of certification (MOC) process for retaining diplomate status.

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

Requested						
Yes	No		(R)	(A)	(N)	(C) Condition/Reason(s)
		ANATOMIC PATHOLOGY				
		Autopsy pathology				
		Surgical pathology: ❖ Operating room consultation and frozen section diagnosis ❖ Gross and microscopic examination of surgical pathology specimens ❖ Interpretation of histochemical and immunohistochemical stains				
		Cytopathology: ❖ Cervicovaginal cytopathology specimens ❖ Non-gynecologic cytopathology specimens including body fluids, bone marrow and fine needle aspirations, biopsy specimens, brushings and washings.				
		CLINICAL PATHOLOGY Interpretation of routine clinical laboratory tests such as: ❖ Hematology ❖ Clinical chemistry ❖ Medical microbiology ❖ Serology ❖ Immunology ❖ Urinalysis ❖ Blood banking				

I 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

Requested privileges reviewed and recommended as indicated above.

______________________________ ______________

Signature of Service or Department Chair 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 DEPENDECY) 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