



**CORE PRIVILEGES
PEDIATRIC SERVICES**

QUALIFICATIONS: MD or DO with successful completion of a 3-year ACGME/AOA accredited residency program in Pediatrics or a 4-year ACGME/AOA accredited Med/Peds program. Board certification is required within seven (7) years post-residency training with ongoing maintenance of diplomate status. Applicants must also have current certification in Neonatal Resuscitation and Pediatric Advance Life Support.

(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)
		CORE PRIVILEGES				
		The admission, consultation, evaluation, and/or treatment of patients from birth to 21 years of age. Core privileges include the care of all newborn infants, including those potential life-threatening illnesses, but excluding ventilator care and advance life support aspects. <i>[Privileges to perform emergency lifesaving procedures are automatically granted, including intensive care of the newborn infant with ventilator care and advanced life support while waiting transfer to a higher level neonatal unit.]</i>				
		SURGICAL PROCEDURES <i>(The following surgical procedures are included in pediatric core privileges unless specifically not requested)</i>				
		Venipuncture				
		Laceration repair				
		Incision and drainage of superficial abscesses				
		Neonatal circumcision				
		Peripheral venous cut-down				
		Umbilical catheterization				
		Intubation (specify inclusive age _____)				
		Peripheral arterial cut-down				
		Exchange transfusion				
		Moderate sedation (requires ACLS certification or pass proficiency exam)				
		DIAGNOSTIC PROCEDURES <i>(The following diagnostic procedures are included in pediatric core privileges unless specifically not requested)</i>				
		Subdural tap				
		Abdominal paracentesis				
		Thoracentesis				
		Peripheral arterial puncture (specify inclusive age ____)				
		Bladder tap				
		Arthrocentesis				
		Skin biopsy				
		Laryngoscopy				
		Lumbar puncture				

PEDIATRIC SUBSPECIALTY PROCEDURES <i>(Requires fellowship or equivalent training and practice utilization of these diagnostic procedures)</i>						
		Renal biopsy				
		Peritoneal dialysis				
		Hemodialysis				
		Pericardiocentesis				
		Lung biopsy				
		Bronchoscopy				
		Hepatic Biopsy				
		Ventricular tap				
		Ventilatory care of neonates (non-emergent)				
		Vasoactive drug drip (non-emergent)				
		Tracheostomy				
		Gastroscopy				
		Sigmoidoscopy				
		Cisternal puncture				
		Myelography				
		Pneumoencephalography				
		Ventriculography				
		Cerebral angiography				
		Intracranial pressure				
		Intracranial pressure monitor placement				
		Angiography, lymph-angiography				
		Chest tube insertion (emergency only)				
		Endoscopy				
		Other:				

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

I have reviewed the requested clinical privileges and supporting documentation and recommend 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
Pediatric Service
Core Privileges

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