



Core Privileges
PULMONARY MEDICINE SERVICE

QUALIFICATIONS: To be eligible for core privileges in Pulmonary Medicine, the applicant must meet the following qualifications:

- Successful completion of an accredited ACGME- or AOA- residency program in Internal Medicine followed by post-graduate training in Pulmonary Disease;
- Current board certification in Internal Medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, and eligible for board certification in Pulmonary Disease; or equivalent credentials as determined by the Chief of Medicine;
- Documentation or attestation of the performance, management or consultative services of at least 100 patients with pulmonary problems during the past two years.

(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:				
		<p>Privileges to admit, evaluate, diagnose, treat, and provide consultative services to patients >13 years of age presenting with conditions, disorders, and diseases of the organs of the thorax or chest; the lungs and airways, cardiovascular and tracheobronchial systems, esophagus and other mediastinal contents, diaphragm, circulatory system.</p> <p>Privileges included but are not limited to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Interpretation of pulmonary function testing <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> Thoracentesis <input type="checkbox"/> Chest tube placement <input type="checkbox"/> Endotracheal intubation and management of mechanical ventilation <input type="checkbox"/> Pleural biopsy <input type="checkbox"/> Percutaneous lung biopsy <input type="checkbox"/> Transbronchial lung biopsy and lymph node aspiration <input type="checkbox"/> Insertion and management of central venous and pulmonary artery catheters <input type="checkbox"/> Emergency cardioversion <p><i>[You may mark through any privilege you will not be doing at this facility and do not wish to request]</i></p>				
		SPECIAL PROCEDURES: (NON-CORE)				
		<p>Sleep Medicine Privileges to admit, evaluate, diagnose, provide consultation to, and treat patients of all ages except where specifically excluded from practice, presenting with conditions or disorders of sleep, e.g. sleep-disordered breathing, circadian rhythm disorders, insomnia, parasomnias, narcolepsy, restless leg syndrome. Privileges include but are not limited to, polysomnography (PSG) (including sleep stage scoring), multiple sleep latency testing (MSLT), actigraphy, sleep log interpretation, home/ambulatory testing, maintenance of wakefulness testing (MWT), Oximetry, Monitoring with Interpretation of EEG, ECG, EOG, Leg EMG+ O₂ saturation, leg movements, thoracic and abdominal movement, and CPAP/BiPAP titration.</p>				<i>ABIM Board certification in Sleep Medicine or scheduled to sit for the sleep medicine examination.</i>

I attest to meeting the minimum qualifications as set forth herein, having performed, managed and/or by provided consultative services to at least 100 patients with pulmonary problems during the past two years. I have also 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 further understand the requirements for consultations and agree to provide **inpatient consultative services within twenty-four (24) hours** for patients admitted to Critical Care (ICU) once a request for consultation has been received.

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