



REHABILITATION SERVICES

Delineation of Privileges

NAME _____

Physicians with these privileges are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training, although not necessarily at the level of a subspecialist. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

- a) diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness;
- b) unexpected complications arise which are outside this level of competence;
- c) specialized treatment or procedures are contemplated with which they are not familiar.

A – Privileges: Physicians granted A-Privileges shall be able to care for all patients, including those gravely ill and whose treatment is complicated, if they supply evidence that their training or experience qualifies them for these privileges. In general, this will apply to physicians who have obtained board certification or equivalent training and experience.

CATEGORY I – PROCEDURES: Minor diagnostic or therapeutic procedures

<u>Privileges Requested</u>	<u>Privileges Granted</u>		<u>Privileges Requested</u>	<u>Privileges Granted</u>	
_____	_____	Lumbar puncture for diagnostic purposes	_____	_____	Joint space orthoparacentesis
_____	_____	Trigger point injection	_____	_____	Incision and drainage of abscess
_____	_____	Repair of laceration	_____	_____	Venipuncture
_____	_____	Venous cutdown	_____	_____	G.I. intubation
_____	_____	Tracheal intubation	_____	_____	Steroid therapy
_____	_____	Debridement	_____	_____	Tendon sheath infiltration
_____	_____	Intravenous catheterization	_____	_____	Arterial puncture

CATEGORY II – PROCEDURES: Procedures which require some special skill acquired through training or experience.

_____	_____	EKG and ECG interpretation	_____	_____	Radiological interpretation
_____	_____	Sigmoidoscopy	_____	_____	Electromyography
_____	_____	Motor point block	_____	_____	Electroencephalogram
_____	_____	Casting	_____	_____	Administration of Moderate Sedation (<i>non-anesthesiologist physicians must be ACLS certified, pass proficiency exam, or receive training through residency program, documentation required</i>)
_____	_____	Percutaneous and transcutaneous nerve stimulation			
_____	_____	Pulmonary rehabilitation			
_____	_____	Motor nerve conduction study			

Admitting Privileges: Requested _____ **Granted** _____

Signature of Applicant

Date

Requested Privileges: Approved as Indicated _____

Denied _____

*If denied, please provide explanation on separate sheet

Signature of Service Chief

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