

APPLICANT NAME: _____

NATCHITOCHEs REGIONAL MEDICAL CENTER
Delineation of Clinical Privileges
INTERNAL MEDICINE

CLINICAL AREAS:

Four (4) levels of clinical privileges may be granted. THE LEVEL OF PRIVILEGES REQUESTED SHOULD BE SPECIFIED*.

LEVEL I: Physicians with these privileges may render emergency care and care of the most preliminary nature. Further management must then be provided by an appropriately qualified physician.

LEVEL II: Physician with these privileges are expected to request consultation in all cases in which doubt exists as to the diagnosis, cases where expected improvement is not soon apparent, and when specialized therapeutic or diagnostic techniques are indicated.

LEVEL III: Physicians with these privileges are expected to have training and/or experience and/or competence on a level commensurate with that provided by specialty training, being board certified or board eligible in the field of internal medicine, psychiatry, neurology, etc.

LEVEL IV: Physicians with these privileges will be board eligible or board certified in the respective subspecialty.

*** Please write the numeral I, II, III, IV to indicate the level of privileges you are requesting in the following areas.**

Level Requested

Level Requested

____ ALLERGY

____ INFECTIOUS DISEASE

____ CARDIOLOGY

____ NEUROLOGY

____ DERMATOLOGY

____ ONCOLOGY

____ ENDOCRINOLOGY

____ PHYSICAL MEDICINE

____ GASTROENTEROLOGY

____ PULMONARY MEDICINE

____ HEMATOLOGY

____ PSYCHIATRY

____ IMMUNOLOGY

____ RHEUMATOLOGY

____ INTERNAL MEDICINE

____ NEPHROLOGY

APPLICANT NAME: _____

**NATCHITOCHEs REGIONAL
MEDICAL CENTER**

**INTERNAL MEDICINE
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Delineation of Privileges

Please indicate below the special procedures which you are requesting privileges:

Requested

- _____ Admission of patients to inpatient services
- _____ Performance of medical History and Physical

CARDIOLOGY

- _____ Consultations Only
- _____ Central Venous Line Insertion
- _____ Echocardiography
- _____ Elective Cardioversion
- _____ Electrocardiographic Interpretation
- _____ Exercise Stress Testing
- _____ Implantation of Cardiac Pacemaker
- _____ Lead or Electronic Device (Transvenous or percutaneous)
- _____ Pericardiocentesis
- _____ Swan Ganz Catheterization
- _____ Transvenous Catheterization
- _____ Cardiovascular CT Angiography
- _____ Holter Monitor Interpretation
- _____ Doppler
- _____ Other:

GASTROLOGY

- _____ Consultations Only
- _____ Colonoscopy
- _____ Duodenoscopy
- _____ Endoscopic Biopsy
- _____ Endoscopic Polypectomy
- _____ Esophageal Dilatation: Bougienage
Pneumatic
- _____ Esophagoscope: Flexible
Rigid
- _____ Gastroscopy
- _____ Needle Biopsy of Liver
- _____ Paracentesis
- _____ Peritoneoscopy
- _____ Per-oral Suction Biopsy of Esophagus,
Stomach, Small Bowel
- _____ Proctosigmoidoscopy with Biopsy
- _____ Suction Biopsy of Colon
- _____ Other:

APPLICANT NAME: _____

**NATCHITOCHEs REGIONAL
MEDICAL CENTER**

**INTERNAL MEDICINE
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Delineation of Privileges

Please indicate below the special procedure which you are requesting privileges:

ALLERGY

____ Consultations Only

____ Other:

PULMONARY DISEASES

____ Consultations Only

____ Arterial Lines

____ Arteriography (Pulmonary)

____ Bronchial Lavage

____ Continuous Pulmonary Ventilation (Pressure, Volume)

____ Endotracheal Intubation

____ Laryngoscopy (Direct)

____ Needle Biopsy of Pleura

____ Percutaneous Lung Biopsy

____ Pulmonary Exercise Testing

____ Swan Ganz Catheterization

____ Thoracentesis

____ Tracheoscopy/Bronchoscopy: Flexible

____ Tracheoscopy/Bronchoscopy: Rigid

____ Transbronchial Lung Biopsy

____ Transtracheal Aspiration

____ Interpretation of Sleep Studies

____ Interpretation of Sleep Studies – Pediatric Only

____ Other:

HEMATOLOGY

____ Consultations Only

____ Bone Marrow: Aspiration

____ Bone Marrow: Needle Biopsy

____ Plasmapheresis

____ Other:

NEPHROLOGY

____ Consultations Only

____ Needle Biopsy of Kidney

____ Other:

APPLICANT NAME: _____

**NATCHITOCHEs REGIONAL
MEDICAL CENTER**

**INTERNAL MEDICINE
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Delineation of Privileges

Please indicate below the special procedures which you are requesting:

DERMATOLOGY

- Consultations Only
 - Skin biopsy
 - Punch Biopsy of Skin and Subcutaneous Tissue
 - Diagnosis and prescription of medical and surgical dermatological condition, diseases, and skin cancers
 - Other:
- _____

MEDICAL ONCOLOGY

- Consultations Only

RHEUMATOLOGY

- Consultations Only
 - Joint Aspiration (diagnostic & injection purposes)
 - Punch Biopsy of Skin and Subcutaneous Tissue
 - Soft tissue (trigger/tender point) injection
 - Synovial Biopsy
 - Apheresis (therapeutic)
 - Other:
- _____

NEUROLOGY

- Consultations Only
- Echoencephalography (Pediatrics)
- Electroencephalogram Interpretation
- Electromyography & Nerve Conduction Studies
- Lumbar Puncture
- Myelography
- Other:

I am mentally and physically capable of performing the privileges in which I am requesting:

Applicant's Signature

Date