

Holy Cross Hospital
 CLINICAL PRIVILEGE FORM
PATHOLOGY

Appt.
 Reappt.
 Additional/change

PHYSICIAN NAME: _____
 Date of Request: _____

Note: Place the appropriate patient age category symbol (s) under the column labeled Requested@.
 An@ = newborns (0-30 days) Ap@ - pediatrics (30 days to 14 yrs) Aa@ - adults (14 and older)
 For self taught training: Submit proof of CME For residency - submit residency certificate.

Clinical Privilege	Requested	Granted <i>(depart chair initials)</i>	Granted with conditions	Number performed last 24 months	TYPE OF TRAINING		ESTIMATED % PAST COMPLICATIONS	
					Residency Fellow	Self Taught	Morbidity	Mortality
ANATOMIC PATHOLOGY								
Cytology								
Fine Needle Biopsy								
Surgical Pathology								
Autopsy pathology								
CLINICAL PATHOLOGY								
Bacteriology								
Chemistry/immunology								
Mycology								
Parasitology								
Serology								
Virology								
Aspiration, preparation, interpretation of peripheral blood & bone marrow aspiration smears.								
Blood transfusion technology								
Arterial Puncture								

I understand that in making this request, I am bound by the applicable Medical Staff Bylaws or policies of the hospital and hereby stipulate that I meet the threshold criteria for each request.

Physician Signature: _____ Date: _____