

# HOLY CROSS HOSPITAL

# PRIVILEGE REQUEST FORM

## PHYSICAL MEDICINE AND REHABILITATION

Applicant: \_\_\_\_\_

In order to be eligible to request clinical privileges for physical medicine and rehabilitation, a practitioner must meet the following minimum threshold criteria:

- Education: MD or DO
- Minimum formal training: The application must be able to demonstrate successful completion of an approved residency training program in Physical Medicine and Rehabilitation.
- Required previous experience: The applicant must demonstrate that he or she has provided inpatient or consultation services to at least 24 patients in the past 12 months.
- References: A letter of reference must come from the person responsible for the applicant's fellowship training or the department chief of another hospital the applicant has been affiliated with for the last two years. Two other letters must come from a primary care physician and a Physical Medicine and Rehabilitation specialist who are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Physical Medicine and Rehabilitation.

If you meet the above criteria, you may request privileges as specified below.

I hereby request core Physical Medicine and Rehabilitation privileges as follows: Privileges include being able to admit, work up, and provide nonsurgical therapeutic treatment to patients presenting with neuromuscular or musculoskeletal disorders, including the provision of consultation.

These privileges do not include any of the following special requests.

For each special request, the applicant must indicate the number of cases he/she has performed (inpatient or outpatient) within the last two years. Special requests for Physical Medicine and Rehabilitation include:

<b>Special Request</b>	<b># of Cases Last 2 years (Any Inpatient or Outpatient)</b>	<b>Granted (Dept. Chair's initials)</b>	<b>Granted with Conditions</b>
Electro diagnostic procedures			
Nerve block			
Muscle biopsy			
Motor point blocks			

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## PHYSICIAN MEDICINE AND REHABILITATION

Applicant: \_\_\_\_\_

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### TYPE OF APPOINTMENT REQUESTED (Please Check One):

- ACTIVE
- ASSOCIATE
- CONSULTING
- LOCUM TENENS

### IN REQUESTING PRIVILEGES, I HEREBY:

1. State that I have read the Medical Staff Bylaws and Rules and Regulations, and agree to abide by them;
2. Understand the criteria and supervision requirements for practice in each service and modality for which privileges are requested;
3. Acknowledge that I meet the criteria for the privileges requested. I understand I am responsible for providing information necessary to verify that I meet all applicable criteria, and that the burden of proof is my responsibility;
4. Confirm that I have completed the appropriate application form for appointment to the Medical Staff;
5. Agree to adhere to the ethics and principles of my profession and participate and respond to the results of the Medical Center's Performance Improvement, and peer review systems; and,
6. State that I have signed a Statement of Conditions release of liability statement allowing representatives of Holy Cross Hospital to request information regarding my current competency, past professional affiliations, and credentials for the privileges requested.

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_