

REHOBOTH MCKINLEY CHRISTIAN HOSPITAL
CLINICAL PRIVILEGES APPLICATION

FAMILY PRACTICE

APPLICANT NAME: _____

NOTE: In the case of an emergency, to the degree permitted by license and regardless of department, staff status or clinical privileges, shall be permitted and shall be assisted by hospital personnel to do everything possible to save a patient from serious harm.

QUALIFICATIONS FOR ALL CORE PRIVILEGES: (Check only the first one which applies to you)

CLASS IV:

___ **Completion of or certification in an Accreditation Council for Graduate Medical Education (ACGME)- or American Osteopathic Association (AOA)- approved subspecialty fellowship in**

Family Practice.

Subspecialty: _____

Members with these privileges are expected to be physicians with experience, training and competence of service as consultants and treating the most extreme illnesses within the subspecialty area.

CLASS III:

___ **Board certification in Family Practice and full time, post residency inpatient family practice experience of at least the last eighteen (18) months consecutively; or**

___ **Active board certification application in Family Practice pending, having completed an ACGME- or AOA-approved residency training program in Family Practice and full time, post residency inpatient family practice experience of at least twenty-four (24) months consecutively; or**

___ **Completion of an ACGME- or AOA-approved residency training program in Family Practice and full time inpatient family practice experience of at least the last five (5) years consecutively.**

Members with these privileges are expected to be physicians with experience, training and competence in their specialty. Such physicians would be expected to request consultation: (1) when hazardous treatment procedures are contemplated; (2) when unexpected complications arise; (3) or in cases in which treatment response seems unduly delayed.

CLASS II:

___ **Board certification in Family Practice, but less than eighteen (18) months inpatient family practice experience; or**

___ **Active board certification application in Family Practice pending, having completed an ACGME-**

or AOA-approved residency training program in Family Practice and less than twenty-four (24) months full time, post residency inpatient family practice experience; or

___ **Completion of an ACGME- or AOA-approved residency training program in Family Practice and less than five (5) years full time, post residency inpatient family practice experience.**

Members with these privileges are required to request consultation in all cases in which doubt exists as to the diagnosis, or in cases in which treatment is not too soon apparent. Illness or problems

requiring skills usually acquired during post internship specialty training.

Other training, please explain:

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ADULT CORE PRIVILEGES:

Family practice privileges include admission, work up, diagnosis, and provision of non-surgical care, generally without life-threatening conditions or complications. This includes care of psychiatric patients, including acute overdose patients (providing that these patients present without evidence of psychosis, major affective disorder, or major complication); alcohol withdrawal; medical care of patients requiring intensive care observation; and care of uncomplicated myocardial infarction (MI) or rule-out MI. **These core privileges do not include any of the privileges listed under Special Adult Privileges.**

SPECIAL ADULT PRIVILEGES: For each special request, you must state the training and number of procedures during training; or number of procedures performed in the last 12 months. If any one or all special privileges are not needed, YOU MUST CHECK "NO" UNDER "PRIVILEGES REQUESTED".

PRIVILEGES REQUESTED RECOMMENDED YES NO		PRIVILEGES YES NO
___ ___ Arthrocentesis.		___ ___
Training/Experience: _____		
___ ___ Cardiac stress testing.		___ ___
Training/Experience: _____		
___ ___ Intravenous conscious sedation.		___ ___
Training/Experience: _____		

NOTE: A PRACTITIONER GRANTED IV SEDATION PRIVILEGES MUST ADHERE TO PATIENT CARE SERVICES POLICY # 14.63.

___ ___ Management of mechanical ventilator.		___ ___
Training/Experience: _____		
___ ___ Paracentesis.		___ ___
Training/Experience: _____		
___ ___ Thoracentesis.		___ ___
Training/Experience: _____		

ADDITIONAL ADULT PRIVILEGES (Specify, stated with training/experience):

CORE PEDIATRIC PRIVILEGES:

Pediatric core privileges include being able to admit and treat the general pediatric patient under the age of 18 years without major complications or serious life-threatening disease. This includes the care of the normal newborn as well as the uncomplicated premature infant equal to or greater than 36 weeks gestation. **These core privileges do not include any of the privileges listed under Special Pediatric Privileges.**

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SPECIAL PEDIATRIC PRIVILEGES: For each special request, you must state the training and number of procedures during training; or number of procedures performed in the last 12 months. If any one or all special privileges are not needed, **YOU MUST CHECK "NO" UNDER "PRIVILEGES REQUESTED"**.

PRIVILEGES
PRIVILEGES
REQUESTED
RECOMMENDED
YES NO

YES NO

___ ___ Circumcision.

___ ___

Training/Experience: _____

___ ___ Pediatric lumbar puncture.

___ ___

Training/Experience: _____

___ ___ Peripheral venous or arterial cutdown, pediatric.

___ ___

Training/Experience: _____

CORE GYNECOLOGICAL PRIVILEGES:

Core gynecological privileges include the care of the uncomplicated gynecological patients (non-operative). **These core privileges do not include any of the privileges listed under Special Obstetrics and Gynecological Privileges.**

SPECIAL OBSTETRICS AND GYNECOLOGICAL PRIVILEGES: Core obstetrics and gynecological privileges must be specifically requested and include being able to perform normal spontaneous vaginal delivery, including prenatal, antepartum and postpartum care; repair of minor vaginal and cervical lacerations; use of outlet forceps; D&C; and the care of the uncomplicated gynecological patients (non-operative).

For each special request, you must state the training and number of procedures during training; or number of procedures performed in the last 12 months. If any one or all special privileges are not needed, **YOU MUST CHECK "NO" UNDER "PRIVILEGES REQUESTED"**.

PRIVILEGES
PRIVILEGES
REQUESTED
RECOMMENDED
YES NO

YES NO

Core obstetrical privileges. ___ ___
 Training/Experience: _____
 Augmentation of labor. ___ ___
 Training/Experience: _____
 Low forceps ___ ___
 Training/Experience: _____
 Premature labor at greater than or equal to 36 weeks. ___ ___
 Training/Experience: _____

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NAME: _____

PRIVILEGES
 PRIVILEGES
 REQUESTED
 RECOMMENDED
 YES NO

	YES	NO
<input type="checkbox"/> <input type="checkbox"/> Repair of 3 rd and 4 th degree vaginal laceration. ___ ___ Training/Experience: _____		
<input type="checkbox"/> <input type="checkbox"/> Vacuum extraction. ___ ___ Training/Experience: _____		

CORE SURGICAL PRIVILEGES:

Core surgical privileges include being able to assist in surgery, suture uncomplicated laceration, I&D of abscess, simple skin biopsy or excision, removal of non-penetrating corneal foreign body, uncomplicated minor closed fractures (not involving traction or major manipulation), uncomplicated dislocations, pre-operative care of surgical patients, and post-operative medical care of surgical patients. **These core privileges do not include any of the privileges listed under Special Surgical Privileges.**

SPECIAL SURGICAL PRIVILEGES: For each special request, you must state the training and number of procedures during training; or number of procedures performed in the last 12 months. If any one or all special privileges are not needed, YOU MUST CHECK "NO" UNDER "PRIVILEGES REQUESTED".

PRIVILEGES
 PRIVILEGES
 REQUESTED
 RECOMMENDED
 YES NO

	YES	NO
<input type="checkbox"/> <input type="checkbox"/> Chest tube placement. ___ ___ Training/Experience: _____		
<input type="checkbox"/> <input type="checkbox"/> Muscle biopsy. ___ ___ Training/Experience: _____		
<input type="checkbox"/> <input type="checkbox"/> Swan-Ganz catheter insertion. ___ ___		

Training/Experience: _____

___ ___ Venous access catheter insertion. _____

Training/Experience: _____

APPLICANT SIGNATURE: _____

DATE: _____

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DEPARTMENT REVIEW:

Comments/Recommendations/Suggestions:

Proctoring Arrangement: I have discussed the need for proctoring of this applicant. The following practitioner(s) who is/are member(s) of the Active Staff of the Medical Staff has/have been assigned:

Signed: _____

Department Chairperson

Date of Review

FAMILY PRACTICE DEPARTMENT.
Medical Staff Department

MSS: REVISED 09/99.