

**REHOBOTH MCKINLEY CHRISTIAN HOSPITAL  
CLINICAL PRIVILEGES APPLICATION**

**PEDIATRICS**

APPLICANT NAME: \_\_\_\_\_

---

**CORE PRIVILEGES:**

Pediatric privileges include treatment of acute and chronic conditions of patients between the ages of birth to young adulthood, the performance of procedures that usually do not carry a significant threat to life (including related admission, consultation; incisions; drainage of superficial abscesses) and the treatment of major or complicated illnesses.

Newborn core privileges include the ability to provide care to all newborns, including those with potentially life-threatening illnesses. Consultation is recommended in extremely complex, life-threatening situations.

**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 CORE PRIVILEGES:** (Check only the first one which applies to you)

**CLASS IV:**

\_\_\_ **Certification in an Accreditation Council for Graduate Medical Education (ACGME)- or American Osteopathic Association (AOA)-approved subspecialty fellowship in Pediatrics.**

**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 Pediatrics; or**

\_\_\_ **Active board certification application pending in Pediatrics, having completed an ACGME- or AOA-approved post graduate training program in Pediatrics; or**

\_\_\_ **Completion of an ACGME- or AOA-approved post graduate training program in Pediatrics and full time pediatric experience for a minimum of the last three (3) 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:**

\_\_\_ **Completion of at least a two year completion of an ACGME- or AOA-approved post graduate training program in Pediatrics; or**

\_\_\_ **Completion of an accredited program in Pediatric Nurse Practice certified by the ANA Credentialing Center, and full time pediatric nurse practice experience for a minimum of the last two (2) years consecutively.**

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.

**PEDIATRICS PRIVILEGES APPLICATION**

NAME: \_\_\_\_\_

**CLASS I:**

\_\_\_ **Completion of an accredited program in Pediatric Nurse Practice and certification by the ANA Credentialing Center, with less than two (2) years of pediatric nurse practice experience**  
 Members with this class of privileges may render emergency care and care of the most preliminary nature. Consultation must be obtained following this.

Other training, please explain:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DATE: \_\_\_\_\_

**SPECIAL 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
___ ___ Exchange transfusion. Training/Experience: _____		___ ___
___ ___ Peripheral arterial cut-down. Training/Experience: _____		___ ___
___ ___ Peripheral venous cut-down. Training/Experience: _____		___ ___
___ ___ Umbilical vein/artery cannulation.. Training/Experience: _____		___ ___
___ ___ Newborn/Pediatric EKG interpretation. Training/Experience: _____		___ ___
___ ___ Intravenous conscious sedation. Training/Experience: _____		___ ___

**NOTE: ALL PRACTITIONERS GRANTED IV SEDATION PRIVILEGES MUST ADHERE TO PATIENT CARE SERVICES POLICY # 2-35**

PEDIATRIC APPLICATION

NAME: \_\_\_\_\_

PRIVILEGES

RECOMMENDED

YES NO

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

\_\_\_\_\_

\_\_\_ \_\_\_

\_\_\_\_\_

\_\_\_

\_\_\_

\_\_\_\_\_

\_\_\_ \_\_\_

APPLICANT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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

PEDIATRICS DEPARTMENT.

Medical Staff Department

MSS: REVISED 09/99.