REHOBOTH MCKINLEY CHRISTIAN HOSPITAL
CLINICAL PRIVILEGES APPLICATION

TELEMEDICINE

APPLICANT NAME: ___________________________________

TELEMEDICINE DEFINITION:

The medical act which occurs when an emergency room or hospital patient, or the result of diagnostic testing of the same, is connected with telecommunication to a physician located outside the RMCH facility, resulting in a written, documented opinion affecting the diagnosis or treatment of the patient.

QUALIFICATIONS FOR TELEMEDICINE 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.**
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 including those within the subspecialty area.

CLASS III:

___ **Board certification.**
Specialty: ___________________________________

___ **Active board certification application pending, having completed an ACGME- or AOA-approved**
post graduate training program in ___________________________________ (list specialty);
or

___ **Completion of an ACGME- or AOA-approved post graduate training program and full time specialty experience for a minimum of the last three (3) years consecutively in**

____
___________________________________ **(list specialty).**

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.

Other training, please explain: ___________________________________
____
____
____

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TELEMEDICINE PRIVILEGES APPLICATION

NAME: ________________________________.

TELEMEDICINE PRIVILEGES: For each request, you must state the training and number of procedures during training; or number of procedures performed in the last 12 months. Check only the telemedicine privileges you are applying for.

PRIVILEGES REQUESTED			PRIVILEGES RECOMMENDED	
YES	NO		YES	NO
___	___	CT interpretation.	___	___
		Training/Experience: ________________________________		
___	___	MRI interpretation.	___	___
		Training/Experience: ________________________________		
___	___	Echocardiogram interpretation.	___	___
		Training/Experience: ________________________________		
___	___	Electrocardiogram (ECG/EKG) interpretation - Adult.	___	___
		Training/Experience: ________________________________		
___	___	Electrocardiogram (ECG/EKG) interpretation – Infant/Pediatric.	___	___
		Training/Experience: ________________________________		
___	___	Electroencephalogram (EEG) interpretation.	___	___
		Training/Experience: ________________________________		
___	___	Holter Monitor Tracing Interpretation.	___	___
		Training/Experience: ________________________________		

OTHER TELEMEDICINE PRIVILEGES (Specify, stated with training/experience):

________________________________ ___ ___

________________________________ ___ ___

________________________________ ___ ___

I certify that I have the appropriate background, experience, and training to perform the telemedicine privilege requested above, including the use of appropriate telecommunication equipment.

APPLICANT SIGNATURE: ____

DATE: ______________________________

TELEMEDICINE PRIVILEGES APPLICATION

NAME: __________________________________.

DEPARTMENT REVIEW:
Comments/Recommendations/Suggestions:

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Signed: ______________________________________
Department Chairperson

____
Date of Review

____
Medical Staff Department

MSS: 07/01.