



## APPLICATION FOR CLINICAL PRIVILEGES (MEDICAL)

Granting, reviewing, and changing of clinical privileges for the staff of FIRST CHOICE COMMUNITY HEALTHCARE (FCCH) will be in accordance with the FCCH policy. Assignment of such clinical privileges is based upon education, clinical training, experience, demonstrated current competence, documented results of patient-care, and other quality review and monitoring deemed appropriate.

The principal of "documented competency" will prevail. Primary care medicine is a dynamic and comprehensive field. Adult medicine, OB-GYN, pediatric care, podiatry, and mental health care are integral components of a Community Health Center's continuity of care. As a result, privileges in these areas are identified to pertain to primary care specialties of pediatrics, internal medicine, family practice, obstetrics/gynecology and podiatry.

The privileges for FCCH will be granted in the following classes:

### LEVEL ONE (GENERAL)

This class includes privileges for uncomplicated, basic procedures and clinical application of cognitive skills. Providers applying for privileges in this class will be graduates of approved medical/osteopathic/Podiatric Medicine schools or licensed schools for physician assistants or nurse practitioners. Providers will be properly licensed, and have demonstrated skills in appropriate general medicine practice.

### LEVEL TWO (RESIDENCY/BOARD CERTIFICATION)

Privileges in this class include Level One privileges, as well as privileges for those procedures and cognitive skills involving more serious medical problems and which normally are taught in residency programs. This may include procedures and clinical application of cognitive skills appropriate to the care in perinatal, podiatric, and psychiatric care units. Providers requesting privileges in this class will have met the criteria in Level One, and will also have either completed training in a residency program and/or will be Board Certified, or will have documented experience, demonstrated abilities and current competence for the requested specific privileges.

**IT SHOULD BE NOTED THAT, EVEN THOUGH A PROVIDER IS ASSIGNED ONE OF THE TWO CLASSES, HE OR SHE MAY ALSO ELECT TO APPLY FOR INDIVIDUAL PRIVILEGES THAT MAY BE CONSIDERED TO BE IN A HIGHER CLASS.**



GENERAL PRIVILEGES	PRIVILEGE REQUESTED	MEDICAL DIRECTOR APPROVAL	SPECIAL CONDITIONS/ COMMENTS
<b>LEVEL TWO</b>			
I&D complicated abscess			
I&D perirectal abscess			
Biopsy, skin			
Ingrown toenail excision			
Joint aspiration and injection of major joints (i.e. shoulder, hip, knee)			
Lacerations, infected			
Suturing of simple 2 layer lacerations			
Flexible Sigmoidoscopy			
Trigger point injection			
Endometrial Biopsy			
IUD insertion			
Cervical Biopsy			
Colposcopy/Cervical Cryotherapy			
Prenatal care with moderate risk, including <ul style="list-style-type: none"> <li>• history of genital herpes</li> <li>• mild chronic hypertension</li> <li>• gestational diabetes</li> <li>• mild pre-eclampsia</li> <li>• thrombophlebitis on Heparin</li> </ul>			
Casting procedures for closed fractures requiring no reduction			
Joint Aspirations			
Procedures involving destruction of nail bed			
Treatment of Closed Dislocations			
Hyfercation and Fulguration			
<b>OTHER PROCEDURES</b>			
Special competency based on appropriate experience, training, credentials, or documentation: _____ _____	_____ _____	_____ _____	_____ _____

I hereby request the privileges identified above. Furthermore, I am physically and mentally capable to perform the above requested privileges.

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

\_\_\_\_\_  
Date

1. \_\_\_\_\_  
Last name                      First                      Middle                      Date of Hire
2. Type of Position:    MD    DO    CNP    CFNP    PA    LISW                      MSW    CNM
3. Action:
- \_\_\_\_\_ Approved    \_\_\_\_\_ Denied:

\_\_\_\_\_  
Medical Director

\_\_\_\_\_  
Date

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4. **Medical/Dental Staff Committee Approval**

- \_\_\_\_\_ Regular Approval  
\_\_\_\_\_ Approval with modification (Specify below)  
\_\_\_\_\_ Denied (specify below)

\_\_\_\_\_  
Chair, Medical/Dental Staff Committee

\_\_\_\_\_  
Date

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5. **Health Care Services Committee**

- \_\_\_\_\_ Recommend Approval  
\_\_\_\_\_ Recommend Approval with Modifications (Specify below)  
\_\_\_\_\_ Recommend Disapproval (Specify below)

\_\_\_\_\_  
Chair, Health Care Services Committee

\_\_\_\_\_  
Date

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6. **Board of Directors**

- \_\_\_\_\_ Approval  
\_\_\_\_\_ Disapproval

\_\_\_\_\_  
Chair, Board of Directors FCCH

\_\_\_\_\_  
Date