CARLSBAD MEDICAL CENTER
APPLICATION FOR CLINICAL PRIVILEGES
DEPARTMENT OF MEDICINE: DERMATOLOGY

NAME: ____ DATE: _________

Life threatening emergency: At the time of a clinical emergency, any practitioner may render whatever care he/she believes to be indicated.

Illness or problem with no serious threat to life.

Requested	Granted	
___	___	Verrucae
___	___	Herpes Simplex and Zoster
___	___	Uncomplicated Acne Vulgaris
___	___	Seborrheic Dermatitis
___	___	Uncomplicated Tinea
___	___	Neurodermatitis
___	___	Nummular Dermatitis
___	___	Dyshidrosis
___	___	Uncomplicated Viral Exanthema
___	___	Obvious drug eruption
___	___	Scabies
___	___	Pediculosis
___	___	Conditions requiring routine excision and drainage of cysts and routine biopsies

Illness or problem requiring skills usually acquired during post internship specialty training, or as a consequence of experience.

Requested	Granted	
___	___	Uncomplicated Psoriasis
___	___	Uncomplicated actinic Keratoses
___	___	Uncomplicated basal cell and squamous cell carcinomas

Criteria for requesting privileges include significant training in and experience in the care of these conditions requiring skills usually achieved only during training sufficient to attain qualification for board certification. Documentation of training, experience and/or certification required.

Requested	Granted	
___	___	All dermatologic conditions
___	___	Routine biopsy or excision relating to a dermatology problem
___	___	Hair transplants
___	___	*Pinch, split and full thickness grafts
___	___	Lip wedges
___	___	Lip shaves
___	___	*Chemical face peels
___	___	*Dermabrasion

Illness or problem requiring an unusual degree of expertise or competence in techniques requiring special skills usually acquired only with experience or subspecialty training.

* Those privileges marked with an * require documentation of training and/or experience in addition to board certification or qualification in the requested subspecialty.

Requested	Granted	
___	___	*X-ray therapy for dermatology
___	___	*Moh's type Chemosurgery/Micrographic surgery
___	___	*Rotation of skin flaps
___	___	*Laser surgery
___	___	*Liposuction
___	___	*Conscious sedation (documented competency by training director or Chief of Anesthesiology)

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APPLICANT'S SIGNATURE: ______________________________ DATE: ____________

Specific privileges denied: ___ Yes ___ No

If yes, please comment: ______________________________

REVIEWED BY: ______________________________
TITLE: ______________________________

Procedures requiring skills usually achieved only during training sufficient to attain eligibility for board certification.

- **Those privileges marked with an *require documentation of training and/or experience in addition to board certification or qualification.**

Procedure	Residency Training or CME Course	# Cases	Fellowship or equivalent training (documented by letter)
X-ray therapy for dermatology	X		X
Moh's micrographic surgery	X	12	X
Rotation of skin flaps	X	12	
Laser surgery	X	12	X
Liposuction	X	12	X
Skin grafting	X	12	
Dermabrasion	X	12	
Chemical face peels	X	12	

AUTHORIZATION FOR BACKGROUND CHECK

By signing below, I grant permission to the Hospital, its medical staff and representatives ("Hospital") to obtain an investigative report, to include state and federal criminal records and driving arrest records, for purposes of processing my medical staff application. I understand that I may request the Hospital to disclose the nature and scope of the investigation requested within five (5) days of my written request made within a reasonable time after the Hospital obtains the information. I also understand that I am entitled to request a summary of my rights with respect to consumer reporting agencies.

____
Print Name

____
Signature

____
Date