

**CARLSBAD MEDICAL CENTER  
APPLICATION FOR CLINICAL PRIVILEGES  
DEPARTMENT OF MEDICINE: NEUROLOGY**

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

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

**Board certified in Psychiatry and Neurology, or Board qualified within the current time limits of the American Board of Psychiatry and Neurology or the American Osteopathic Board of Psychiatry and Neurology.**

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

**Neurology**

Requested	Granted	
___	___	Diseases of the central nervous system including the brainstem and spinal cord
___	___	Diseases of peripheral nerves, including traumatic, but not requiring surgical repair
___	___	Diseases of the brachial and lumbar plexuses, including traumatic but requiring surgical repair
___	___	Diseases of the neuromuscular junction, including toxic and metabolic conditions, but not requiring ventilatory support
___	___	Diseases of muscle, including dystrophies, inflammatory and metabolic myopathies, but not requiring ventilatory support
___	___	Diseases involving the cranial nerves and/or the brainstem, but not requiring ventilatory or circulatory support or parental alimentation
___	___	Hypertension
___	___	Arthritis
___	___	Diabetes mellitus without coma, including acidosis
___	___	Psychiatric disease, including character disorders, neurosis and psychosis but not considered life-threatening
___	___	Cerebral or brainstem infarction, embolus or hemorrhage, with altered level of consciousness but without coma
___	___	Diseases of the central and/or peripheral nervous systems, myoneural junction and/or muscle requiring ventilatory and/or vascular assistance, with or without parenteral fluid/electrolyte/caloric maintenance
___	___	Epilepsy, including cases difficult to control, but not including status epilepticus
___	___	Accelerated hypertension with encephalopathy but without coma
___	___	Infectious diseases in patients with neurological impairment, including pulmonary, renal and blood stream infections, endocarditis, purulent and non-bacterial meningitis, encephalitis and focal supportive encephalitis (abscess), but without focal cerebral mass effect
___	___	Renal, pulmonary and cardiac insufficiency and decompensation in patients with neurological disease
___	___	Systemic and focal vasculitides with involvement of the central nervous systems or the somatic musculature
___	___	Coma from all causes, including toxic, metabolic, infectious, inflammatory, degenerative disease, that due to endocrinopathy, with or without increased intracranial pressure (due to focal mass or of a more generalized nature)
___	___	Status epilepticus
___	___	All diseases of the central and/or peripheral nervous systems, myoneural junctions and/or somatic musculature leading to the need for ventilatory and/or vascular life-support systems, including patients requiring parental alimentation, including hyperalimentation
___	___	Invasive monitoring procedures including intracranial pressure monitoring, central venous pressure lines, intra-arterial pressure lines and Swan-Ganz catheters and other modifications

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**Psychiatric illnesses considered life-threatening, including but not limited to depressive neurosis with suicidal ideation, paranoid schizophrenia with homicidal tendencies and others.**

Requested	Granted	
___	___	*Conscious sedation (Documented competency by training director or Chief of Anesthesiology)
___	___	*Electroencephalography, both recording and interpretation
___	___	*Electromyography and nerve conduction velocity studies
___	___	*Cisterna magna and high cervical vertebral interspace puncture
___	___	*Intrathecal administration of medications
___	___	*Muscle biopsy
___	___	*Myelography/arteriography
___	___	*Transcutaneous angiography of the cerebral vessels

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Specific privileges denied:            
  Yes  No

If yes, please comment: \_\_\_\_\_  
\_\_\_\_\_

REVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
TITLE: \_\_\_\_\_

Procedure	Board Certified and/or Fellow	Didactic & Hands on Experience	# Case Proctored/ Experience
Electroencephalography, recording and interpretation	X	X	
Electromyography/nerve conduction velocity studies	X - Electromyography	X	X
Cisterna magna & high cervical interspace puncture	X	X	X
Intrathecal administration of medications		X	
Muscle biopsy	X	X	X - Case by case basis
Myelography	X	X	X - Case by case basis
Transcutaneous angiography of the cerebral vessels	X	X	X - Case by case basis



### **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.

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Print Name

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Signature

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Date