

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

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 Internal Medicine requested, or Board qualified within the current time limits specified by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.

Guidelines and Scope of Practice as defined by the American College of Occupational and Environmental Medicine (ACOEM). If designated as a Medical Review Officer (MRO) documentation of continuing medical education (CME) credit for instruction as medical review officers is requested.

Requested	Granted	
___	___	Health evaluation of employees
___	___	Pre-assignment – health status, including assessment of emotional status
___	___	medical history
___	___	occupational history (complete work history)
___	___	assessment of the organs or systems likely to be affected by the assignment
___	___	evaluation of the description and demands of the job to which assignment is being
___	___	considered
___	___	compliance with OSHA, NRC, EPA, MSHA, DOT, ADA, or other pertinent regulations
___	___	Periodic medical surveillance
___	___	Post-illness or injury evaluation
___	___	Diagnosis and treatment of occupational and environmental injuries or illnesses, including rehabilitation
___	___	routine non-procedural medical care
___	___	routine primary care procedures
___	___	rehabilitation potential determination
___	___	rehabilitation placement propriety
___	___	prescription/administration/supervision of therapies
___	___	prescription/administration/supervision of physical therapies
___	___	work determination status
___	___	impairment and disability evaluation
___	___	work hardening and stimulation program direction
___	___	ergometric studies
___	___	muscle strength testing
___	___	range of motion evaluation
___	___	coordination testing
___	___	radiological and lab procedures (interpretation only)
___	___	Ergonomic and/or other workplace evaluations
___	___	Implementation of programs for the use of indicated personal protective devices
___	___	Evaluation, inspection, abatement and training of personnel regarding workplace hazards and
___	___	hazardous materials
___	___	Toxicologic assessments
___	___	Immunization against possible occupational infections
___	___	Assistance in rehabilitation of alcohol and drug-dependent employees or those with emotional disorders
___	___	Palliative treatment of disorders to allow completion of workshift
___	___	Assistance in control of illness-related absence from job
___	___	Assistance in evaluation of personal health
___	___	Health education and counseling
___	___	Participation in planning, providing and assessing the quality of employee health benefits



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