

CARLSBAD MEDICAL CENTER

PATHOLOGY
APPLICATION FOR PRIVILEGES

NAME OF APPLICANT: _____

BOARD CERTIFICATION: _____ DATE: _____

All practitioners requesting privileges are to be board certified by the American Board of Pathology or by the American Osteopathic Board of Pathology, or fully trained in an accredited Pathology residency program recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

CHECK EACH AREA FOR WHICH YOU ARE REQUESTING PRIVILEGES:

R = Requested G = Granted D = Denied

R G D
CLINICAL CHEMISTRY

[] [] [] Consultation based on the selection and interpretation of clinical chemistry techniques

HEMATOLOGY AND COAGULATION

[] [] [] Consultations regarding selection and interpretation of hematologic laboratory

[] [] [] Hematology

[] [] [] Blood Component Therapy

[] [] [] Exchange Transfusions

MICROBIOLOGY AND IMMUNOLOGY

[] [] [] Consultations as to diagnosis and therapy based on selection and interpretations of microbiologic techniques

ANATOMIC PATHOLOGY

Cytology Interpretations

[] [] [] - Evaluation of endocrine status
[] [] [] - Extragenital cytology
[] [] [] - Cancer diagnosis including FNA biopsy of superficial tissue

Biopsy Interpretations

[] [] [] Histologic interpretation of tissue sections including the use of frozen sections

[] [] [] Surgical Specimens- gross and microscopic

[] [] [] Consultation and teaching regarding clinical pathologic autopsy correlations

OTHER

[] [] [] Specify: _____
[] [] [] Specify: _____

I certify that I have had the necessary training and experience to perform the procedures that I have requested.

NAME OF APPLICANT (Please Print)

SIGNATURE

DATE

APPROVALS

All privilege delineations have been individually considered and have been recommended based upon the practitioner's specialty, licensure, specific training, experience, health status, current competence and peer recommendations.

APPLICANT MAY PERFORM PRIVILEGES AND PROCEDURES AS INDICATED:

EXCEPTIONS/LIMITATIONS:

(specify)

Surgery Department Chairperson

Date

Medical Staff Executive Committee

Date

Board of Trustees

Date



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