

CARLSBAD MEDICAL CENTER PEDIATRICS CLINICAL PRIVILEGE DELINEATION FORM

NAME OF APPLICANT: _____

BOARD CERTIFICATION: _____

DATE of CERTIFICATION: _____

Privileges in Pediatrics are granted for both clinical cognitive areas and specific procedures. All practitioners requesting Pediatric privileges are to be board certified by the American Board of Pediatrics or by the American Osteopathic Board of Pediatrics or fully trained in an accredited Pediatric residency program recognized by the American Board of Medical Specialties or the American Osteopathic Association. Initial applicant physicians, who have successfully completed an American College of Graduate Medical Education (ACGME) or AOA approved residency but who are not yet board certified, must present evidence to the medical staff that they are an active candidate for Board Certification. All practitioners requesting privileges must demonstrate appropriate training, experience and current competence of all privileges requested.

Recent clinical experience is also required of all applicants for appointment and reappointment. Recent clinical experience for initial appointment and reappointment is defined as having performed at least 24 hospital admissions or procedures at a JCAHO-accredited hospital within the last two years. The variety and type of clinical services performed within the last two years must be reflective of the scope of General Pediatric Medicine and the Pediatric privileges requested.

R=REQUESTED, G=GRANTED, D=DENIED

NOTE: For asterisked (*) privileges, enter the # and location performed in the last 2 years.

R G D
[] [] []

GENERAL COGNITIVE PRIVILEGES INCLUDING ALL BELOW:

	# Performed	Location Performed
ADMITTING AND ATTENDING PRIVILEGES		
Inpatient Care of the General Pediatric Patient		
Admission to the Level 1 well baby nursery		
Admission to the Level 2 special care nursery		
Attend Deliveries		
Critical Care Admission and Management*	_____	_____

NAME OF APPLICANT: _____

PRIVILEGES LEVELS	<u>PROCEDURAL PRIVILEGES</u>
LEVEL 1	<p>USUAL AND CUSTOMARY PEDIATRIC PROCEDURAL PRIVILEGES</p> <ol style="list-style-type: none"> 1. These procedures are usually performed by Board Certified Pediatricians or by those who have successfully complete an approved Pediatric residency training program. AND 2. Documentation of specific training, experience, and current competence in Level 1 privileges MAY be required; AND 3. Individual Level 1 privileges MAY be proctored as defined on this privilege delineation form for initial appointment and/or reappointment.
LEVEL 2	<p>ADVANCED PEDIATRIC PROCEDURAL PRIVILEGES</p> <ol style="list-style-type: none"> 1. These procedural privileges may be performed by board certified, board eligible, or fully trained pediatricians; AND 2. REQUIRE DOCUMENTATION of specific training, experience, and current competence in Level (2) privileges requested; AND 3. Individual Level 2 procedural privileges must be proctored as defined on this privilege delineation form for initial appointment and reappointment.

R=REQUESTED, G=GRANTED, D=DENIED

NOTE: For asterisked (*) privileges, enter the # and location performed in the last 2 years.

R G D

[] [] [] **LEVEL 1 CORE PROCEDURAL PRIVILEGES INCLUDING ALL BELOW**

	# Performed	Location Performed
Arterial Puncture		
Umbilical Arterial Line*	_____	_____
Umbilical Venous Line*	_____	_____
Central Venous Line*	_____	_____
Cardioversion – emergent		
Newborn Resuscitation* (requires NRP)		
Debridement		
I &D Abscess		
Minor Laceration Repair		
Suprapubic Bladder Tap		
Circumcision of Newborn Infant*	_____	_____
Lumbar puncture		
Intraosseous Line		
Endotracheal Intubation*	_____	_____
Chest tube placement (emergency only)*	_____	_____
Thoracentesis		
Ventilator management*	_____	_____

NAME OF APPLICANT: _____

R=REQUESTED, G=GRANTED, D=DENIED

NOTE: For asterisked (*) privileges, enter the # and location performed in the last 2 years.

LEVEL 2 ADVANCED PROCEDURAL PRIVILEGES

R	G	D		# Performed	Location Performed
[]	[]	[]	Assist in Surgery*	_____	_____
[]	[]	[]	Pediatric (<15 years) Moderate Conscious Sedation*	_____	_____
			<i>For Conscious Sedation policy see attachment C</i>		
[]	[]	[]	Cut Down-Peripheral Vessel*	_____	_____
[]	[]	[]	Internal Jugular puncture or line*	_____	_____
[]	[]	[]	External Jugular puncture or line*	_____	_____
[]	[]	[]	Tympanocentesis*	_____	_____
[]	[]	[]	Pericardiocentesis*	_____	_____
[]	[]	[]	Abdominal Paracentesis*	_____	_____
[]	[]	[]	Knee joint aspiration*	_____	_____
[]	[]	[]	Bone marrow aspiration*	_____	_____
[]	[]	[]	Management of Simple Fractures and Dislocations*	_____	_____

OTHER (Submit documentation of training/experience)

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

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

NAME OF APPLICANT (Please Print)

SIGNATURE

DATE

APPROVALS

All privileges delineated 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:

NONE

SPECIFY: _____

Medicine Department Chair

DATE

Medical Executive Committee

DATE

Board of Trustees

DATE

NAME OF APPLICANT: _____

PEDIATRIC CRITERIA FOR CLINICAL PRIVILEGES

Privileges followed by one asterisk are identified in this table. Please submit required documentation when applicable at the time of appointment or reappointment. The numbers indicated in this table represent minimal criteria for appointment and reappointment and additional documentation of training, experience, and/or current competence may be requested and proctoring may be required at any time by the Department Chairman or the Executive Committee.

PROCEDURE	TRAINING/EXPERIENCE	NUMBER OF PROCEDURES FOR INITIAL APPOINTMENT	NUMBER OF PROCEDURES EVERY 2 YEARS	NUMBER OF CASES PROCTORED INITIALLY
GENERAL COGNITIVE PRIVILEGES				
Critical Care Admission & Management*	Doc. of Successful Performance	5	0	0
LEVEL 1 CORE PROCEDURAL PRIVILEGES				
Umbilical Arterial Line*	Doc. of Successful Performance	5	2	1
Umbilical Venous Line*	Doc. of Successful Performance	5	2	1
Central Venous Line*	Doc. of Successful Performance	10	0	0
Newborn Resuscitation*	Current NRP	NA	NA	NA
Circumcision of Newborn Infant*	Doc. of Successful Performance	10	2	1
Endotracheal Intubation*	Doc. of Successful Performance	10	0	0
Chest Tube Placement (Emergency only)*	Doc. of Successful Performance	0	0	0
Ventilator Management*	Doc. of Successful Performance	5	0	0
LEVEL 2 ADVANCED PROCEDURAL PRIVILEGES				
Assist in Surgery*	Doc. of Successful Performance	3	2	0
Conscious Sedation – Pediatric (<15 years) Moderate Sedation or Analgesia*	See Attachment C	2	1	0
Cut Down-Peripheral Vessel*	Doc. of Successful Performance	5	2	1
Internal Jugular puncture or line*	Doc. of Successful Performance	5	2	1
External Jugular puncture or line*	Doc. of Successful Performance	5	2	1
Tympanocentesis*	Doc. of Successful Performance	5	2	1
Pericardiocentesis*	Doc. of Successful Performance	5	2	1
Abdominal Paracentesis*	Doc. of Successful Performance	5	2	1
Knee joint aspiration*	Doc. of Successful Performance	5	2	1
Bone marrow aspiration*	Doc. of Successful Performance	5	2	1
Management of Simple Fractures and Dislocations*	Doc. of Successful Performance	5	2	1

MEDICAL STAFF CREDENTIALING CRITERIA FOR CONSCIOUS SEDATION

Moderate Sedation or Analgesia

Separate privileges are granted for the categories of adult and pediatric (< 15 years) moderate sedation or analgesia, based on documentation of current competency.

All medical staff requesting any conscious sedation privilege must complete and document a review of the current medical staff conscious sedation policy. In addition to the required review of the conscious sedation policy, practitioners requesting privileges in conscious sedation must meet requirements of either #1 **or** #2 listed below:

1. Documentation of training, experience and current competence related to the use of moderate sedation or analgesia, **and** successful performance of at least (1) moderate sedation/analgesia case in the last (2) years for each category of moderate sedation or analgesia applied for and (2) sedation/analgesia cases at initial appointment **OR**
2. Documentation of relevant training and experience **AND**
 - a. Attendance at a Carlsbad Medical Center sponsored CME program on moderate sedation/analgesia **or** review of the videotape of such conference **and** achievement of a score of 85% or higher on the moderate sedation/analgesia post-test, **AND** provisional privileges will be granted pending outcome review.



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