

Delineation of Privileges – *Family Practice*

Please indicate by a check in the requested column those privileges that are commensurate with your clinical ability, training and experience for which you are applying.

<b>CORE PRIVILEGES:</b>	Requested	Not Requested	Approved	Denied
General Internal Medicine (Representative Diagnosis)				
General Pediatric Medicine (Representative Diagnosis)				
Metabolic & Endocrine Disease				
Hepatic Diseases				
Gastrointestinal Diseases				
Pulmonary Disease				
Renal Disease				
Cardiac Diseases				
Rheumatology				
Hematologic/Oncologic Disease				
Neurologic Diseases				
Allergy				
Infectious Disease				
Severe Infection Management				

<b>SPECIALTY PRIVILEGES</b>	Requested	Not Requested	Approved	Denied
Joint Aspiration				
TPN				
Wound Aspiration				
Incision of Superficial Abscess				
Hemo Dialysis / Peritoneal Dialysis				

Your initials as used in Medical Records \_\_\_\_\_

Your signature as used in Medical Records \_\_\_\_\_

I, \_\_\_\_\_, hereby request privileges in **Family Practice** as indicated. I understand that privileges requested may differ from those approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

Physician \_\_\_\_\_ Date \_\_\_\_\_

<b>APPROVAL:</b>	
Comments:	
_____	
_____	
_____	
_____	_____
Medical Director	Date