SSM ST. CLARE SURGICAL CENTER

CLINICAL PRIVILEGES IN PAIN MANAGEMENT

Initial ☐ **Renewed** ☐

Name ____________________________ **Effective from** ___/___/___ **to** ___/___/___

Applicant: Please initial in the box in the R column for each privilege requested.

R = Requested G = Recommended As Requested C = Recommended with Conditions N = Not Recommended

Note: If Recommendations for clinical privileges are conditional, modified or are not recommended, the specific condition and its reason must be stated where indicated on the last page of this form.

R	G	C	N	General Pain Management Privileges
☐	☐	☐	☐	Administration of Ablative Blocks
☐	☐	☐	☐	Peripheral Nerve Blocks
☐	☐	☐	☐	Botox Injections
☐	☐	☐	☐	Discograms
☐	☐	☐	☐	Diagnostic / Therapeutic Sympathetic Blocks
☐	☐	☐	☐	Epidural Blood Patch
☐	☐	☐	☐	Epidural Steroid Injections (Cervical, Thoracic, Lumbar)
☐	☐	☐	☐	Epidurogram
☐	☐	☐	☐	Epiduroscopy
☐	☐	☐	☐	Facet Injections
☐	☐	☐	☐	Intradiscal Thermal Therapy
☐	☐	☐	☐	Peripheral Nerve Stimulators
☐	☐	☐	☐	Percutaneous Nucleoplasty
☐	☐	☐	☐	Placement of Intrathecal Catheter and Infusion Pumps
☐	☐	☐	☐	Placement of Spinal Cord Stimulators
☐	☐	☐	☐	Radiofrequency Neuroblation of Facet Nerves
☐	☐	☐	☐	Trigger Point Injections

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R	G	C	N	Other
☐	☐	☐	☐	IV/Conscious Sedation
☐	☐	☐	☐	X-Ray Interpretation: C-Ann

I have requested only those specific privileges for which my education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at ***SSM St. Clare Surgical Center***. I request privileges for the above procedure(s) with the understanding that I consider myself to be in good physical and mental health and I am capable of providing quality care that is acceptable to ***SSM St. Clare Surgical Center***.

I verify/confirm that I have am currently privileged to perform the same procedures that I am requesting, above, at a local, Joint Commission Accredited, State licensed, and Medicare approved hospital.

Practitioner Signature ____________ Practitioner Name: Type or Print ____________ Date ____________

Approved by the Credential/Medical Advisory Committee of the Medical Staff and duly appointed to the Medical Staff by the Governing Board.

Medical Director Approval ____________ Date ____________

Governing Board ____________ Date ____________

If Recommendations for clinical privileges are conditional, modified or are not recommended, the specific condition and reason(s) must be stated on this last page and practitioner notified in writing within three days by Administrator and Medical Director.