

Heart Hospital of New Mexico  
Medicine Department  
**Physical Medicine and Rehabilitation**

Delineation of Core Privileges

**PHYSICAL MEDICINE AND REHABILITATION-CORE I**

**ELIGIBILITY CRITERIA:** To be able to request these clinical privileges, the applicant must meet the criteria below:

1. **MD, DO**
2. **Completed additional education/training as follows:**
  - Completion of an accredited Residency Program in PM&R;
  - and
  - Must be certified by the American Board of PM&R within 5 years of staff appointment.

**NEW APPLICANTS MUST BE** Board Eligible and complete Board Certification within 5 years of application/approved Medical Staff membership.

3. **Be able to secure clinical references from:**

**Initial Applicant References:**

-Residency Director or Chief of Department of which you were affiliated at another hospital within the last two years

-One Physician not presently associated or about to become partners with.

**PHYSICAL MEDICINE AND REHABILITATION  
CORE I PRIVILEGES**

Performance of non-surgical procedures (including related admission, consultation, work-up, pre- and post operative care) to correct or treat various conditions, illness and injuries in Physical Medicine and Rehabilitation.

MINIMUM CRITERIA OF 50 PM&R CORE I PROCEDURES WITHIN THE LAST TWO YEARS CAN BE FULFILLED FROM OTHER HOSPITAL AFFILIATIONS.

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Core Privilege Request Form

Having reviewed the requirements for each set of privileges in the following pages, I would request the following privileges:

*Place a check mark in the appropriate box for each set of privileges. Cross out any procedures not currently performed in your clinical practice.*

Privilege	Procedures	Requested	Not Requested
<b>CORE I PRIVILEGES</b>			
	-Rehabilitation (plan, consult, treatment) -Nerve Conduction study -Needle electromyography -Ergometric Studies		
<b>MODERATE SEDATION</b> <i>(Complete Separate Form)</i>			
<b>RESTRAINT PRIVILEGES</b>			

I attest by signature that I have met the minimum criteria of procedures/diagnoses management within my clinical practice for the procedures requested above, and I agree to provide documentation of said procedures/diagnoses management if requested.

\_\_\_\_\_  
 Applicant Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name

**The Department Chairperson accepts this applicant's attestation that he/she meets the minimum criteria for privileges requested.**

\_\_\_ Yes \_\_\_ No

\_\_\_\_\_  
 Department Chair Signature

\_\_\_\_\_  
 Date