



Privileges in Critical Care Medicine

Name: _____

Please Print

MEDICAL STAFF CATEGORY REQUESTED:

- Active** – Uses Stanford Hospital & Clinics (SHC) as a primary hospital and regularly admits/treats, consults, patients at this facility, or is regularly involved in medical staff functions. (Minimum 11 pt contacts per year)
- ONLY** provide care of patients in the SHC Emergency Department, ASC, Cath Lab, Cancer Center or Endo Unit – requires Active or Courtesy Status at LPCH

Please indicate any teaching title you may hold with the Stanford School of Medicine:

- Faculty (MCL or UTL) Clinical Educator Adjunct Clinical Faculty

Teaching Title: _____

REQUESTED	PROCEDURE	INITIAL CRITERIA	RENEWAL CRITERIA	PROCTORING REQUIREMENTS
CORE PRIVILEGES				
<input type="checkbox"/>	<p><u>Privileges included in the Core:</u></p> <p><u>Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges</u></p> <p>Privileges to admit, evaluate, diagnose, perform history and physical exam, provide treatment or consultative services to patients of all ages—except as specifically excluded from practice and except for those special procedure privileges listed below—in need of critical care. Core privileges include the following high-risk, high-volume, and problem-prone procedures, which are commonly performed by the intensivist in the critically ill patient:</p> <ul style="list-style-type: none"> ▪ Airway maintenance, including intubation ▪ Ventilator management ▪ Insertion and management of arterial, central venous, and pulmonary artery catheters ▪ Calibration and operation of hemodynamic recording systems ▪ Diagnostic paracentesis ▪ Tube thoracostomy ▪ Gastroesophageal balloon tamponade ▪ Emergency pericardiocentesis ▪ Emergency tracheostomy/cricothyroidotomy 	<p>Subspecialty board certification in critical care medicine by the American Board of Medical Specialties, or the American Osteopathic Association, or have completed a critical care fellowship in the past four (4) years or foreign equivalent training/board.</p> <p style="text-align: center;"><u>OR</u></p> <p>Demonstration of the provision of inpatient care to at least 50 patients in a critical care unit during the past 12 months as an attending physician.</p>	<p>Appropriate number of cases performed per year as based on Category</p> <p><i>Reappointments: please be prepared to provide a list of cases performed at facilities other than SHC if requested.</i></p> <p>_____ # of cases in 2 years</p>	<p>5 chart reviews</p>

SPECIAL PRIVILEGES (MUST ALSO MEET THE CRITERIA ABOVE)				
REQUESTED	PROCEDURE	ADDITIONAL CREDENTIALING CRITERIA	# of Cases performed in past 2 yrs **	Proctoring Requirements
<input type="checkbox"/>	Administration of Moderate Sedation	In accordance with Hospital Sedation Policy and completion of the SHC sedation exam	Sedation exam every 4 years	5 chart reviews
<input type="checkbox"/>	Use of fluoroscopy equipment (or supervision of other staff using the equipment)	'Radiology Supervisor and Operator Certificate' or 'Fluoroscopy Supervisor and Operator Permit' required	Maintenance of valid Fluoroscopy or Radiology Certificate	
<input type="checkbox"/>	Percutaneous tracheostomy/cricothyrotomy tube placement (Seldinger technique)	Documentation of additional training and experience	_____ # of cases in 2 years	5 chart reviews

**** On a separate sheet of paper, please describe any major, unexpected complications you have encountered for any of the Core Privileges or Additional Privileges you are requesting**

NOTE: PROCTORING IS REQUIRED FOR ALL INITIAL PRIVILEGES REQUESTED and MUST BE COMPLETED WITHIN 12 MONTHS

ACKNOWLEDGMENT OF PRACTITIONER:

I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at Stanford Hospital & Clinics. I also acknowledge that my professional malpractice insurance extends to all privilege I have requested.

I understand that in exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

Applicant Signature: _____ Date _____

If sending by email, type your name in the box above.
 If sending by mail, please print first and then sign.