STANFORD HOSPITAL & CLINICS
Stanford University Medical Center

Privileges in Dermatology Service

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)*
☐ **Courtesy-Admitting** – *Member in good standing in another TJC, AAAHC or AAAASF accredited hospital, and admits/treats 3 – 10 patients per year at SHC*
☐ **Courtesy-Teaching** – *Treats SHC patients only when incident to performing clinical teaching responsibilities. Must have teaching appointment with the Stanford School of Medicine*

☐ ***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				
☐	Privileges included in the Core: **Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges** Privileges to admit, evaluate, diagnose, consult, perform history and physical exam, provide non-surgical therapy to patients with illnesses or injuries of the integumentary system (epidermis, dermis, subcutaneous tissue, hair, nails and cutaneous glands), including consultation and the performance of : • Allergy and immunodermatology • Clinical pathology • Cutaneous microbiology • Dermatologic surgery including biopsy techniques, cryosurgery, electrosurgery, excisions, surgery with appropriate closures including small flaps and grafts, complex closures, laser surgery, nail surgery, sclerotherapy • Dermatopathology • Phototherapy and photochemotherapy • Radiotherapy • Microscopy – fluorescence, electron, cytological	Successful completion of an ACGME or AOA-accredited residency in dermatology or foreign equivalent training. **AND Either** Current certification or active participation in the examination process leading to certification in dermatology by the American Board of Dermatology or the American Osteopathic Board of Dermatology or foreign equivalent training/board. **OR** Documentation or attestation of the management of dermatologic problems for at least 100 inpatients or outpatients as the attending physician (or senior resident)	Appropriate number of cases performed per year as based on Category _____# of cases in 2 years	5 Chart Reviews

SPECIAL PRIVILEGES
(MUST ALSO MEET THE CRITERIA ABOVE)

REQUESTED	PROCEDURE	ADDITIONAL CREDENTIALING CRITERIA	# of Cases performed in past 2 yrs **	Proctoring Requirements
☐	Administration of Moderate Sedation	In accordance with Hospital Sedation Policy and completion of the SHC sedation exam	Sedation exam every 4 years	3 chart reviews
☐	Treatment of patients in outpatient clinics at Stanford Hospital & Clinics	Must have teaching appointment through the Stanford School of Medicine.		3 chart reviews
☐	Admit, treat, or provide follow-up care for inpatients ages 14 years or younger	Must have membership and privileges at Lucile Packard Children's Hospital		3 chart reviews
☐	Staged flaps	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	MOHS micrographic surgery	Mohs/Procedural Derm Fellowship	_____# of cases in 2 years	5 chart reviews
☐	Liposuction (up to 3 liters)	Procedural Derm Fellowship	_____# of cases in 2 years	5 chart reviews
☐	Blepharoplasty Upper/Lower	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Canthopexy	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Brow lift	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Soft Tissue Augmentation Fillers < then 1 year duration	Documentation of current training for this procedure in Residency	_____# of cases in 2 years	3 chart reviews
☐	Soft Tissue Augmentation Fillers > then 1 year duration	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Botox injections upper face	Documentation of current training for this procedure in Residency	_____# of cases in 2 years	3 chart reviews
☐	Botox lower face/neck/axilla/hands	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Ablative Resurfacing Procedures	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Ambulatory Phlebectomy	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Lipotransfer	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Rhytidectomy	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Hair transplant	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Neck lift	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Laser surgery/therapy	Documentation of current training for this procedure in Residency	_____# of cases in 2 years	3 chart reviews
☐	Chemical Peels	Documentation of current training for this procedure in Residency	_____# of cases in 2 years	3 chart reviews

☐	Chin Implant	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Limited Incision Brachioplasty	Procedural Derm Fellowship	_____# of cases in 2 years	3 chart reviews
☐	Limited Skin only Abdominoplasty	Procedural Derm Fellowship	_____# of cases in 2 years	3 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.