STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

Privileges in Immunology/Rheumatology 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, CE or UTL) ☐ Adjunct Clinical Faculty

Teaching Title: ____

REQUESTED	PROCEDURE	INITIAL CRITERIA	RENEWAL CRITERIA	PROCTORING REQUIRMENTS
CORE PRIVILEGES				
☐	***<u>Privileges included in the Core:</u>*** ** Privileges to admit, evaluate, diagnose, consult, perform history and physical exam, and provide non-surgical treatment to patients presenting with immunologic disorders and conditions or patients with rheumatic or suspected rheumatic diseases. **<u>Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges</u>** Privileges include: • Diagnostic aspiration of synovial fluid from diarthrodial joints, bursae, and tenosynovial structures • Therapeutic injection of diarthrodial joints, bursae, tenosynovial structures and entheses, and arthrocentesis	Successful completion of an ACGME or AOA-accredited residency/fellowship in immunology or rheumatology or foreign equivalent training. **<u>AND Either</u>** Eligibility/certification or active participation in the examination process leading to certification in immunology or rheumatology by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine or foreign equivalent training/board. **<u>OR</u>** Documentation or attestation of the treatment of at least 24 inpatients or outpatients with immunologic and rheumatology problems, as the attending physician (or fellow), at an accredited facility, during the past two years.	Appropriate number of cases performed per year as based on Category ***Reappointments: please be prepared to provide a list of cases performed at facilities other than SHC if requested.*** _______# of cases in 2 years Minimum 22 cases in the past two years	5 chart reviews

SPECIAL PRIVILEGES
(MUST ALSO MEET THE CRITERIA ABOVE)

REQUESTED	PROCEDURE	ADDITIONAL CREDENTIALING CRITERIA (if applicable)	# of Cases performed in past 2 yrs **	
☐	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		
☐	Treatment of patients in outpatient clinics at Stanford Hospital & Clinics	Must have teaching appointment through the Stanford School of Medicine.		
☐	Joint lavage	Rheumatology Fellowship	_______# of cases in 2 years 1 case minimum required	5 chart reviews
☐	Chemotherapy administration for rheumatologic disorders using FDA-approved drugs	Rheumatology Fellowship and/or Immunology Fellowship	_______# of cases in 2 years 5 cases minimum required	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 UNLESS OTHERWISE NOTED BY SERVICE CHIEF. 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.