STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

Privileges in Infectious Disease

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) ☐ Clinician Educator ☐ Adjunct Clinical Faculty

Teaching Title: ____

REQUESTED	PROCEDURE	INITIAL CRITERIA	RENEWAL CRITERIA	PROCTORING REQUIREMENTS
CORE PRIVILEGES				
☐	***<u>Privileges included in the Core:</u> ***** Privileges to admit, evaluate, diagnose, consult, perform history and physical exam, and provide treatment or consultative service to patients with infectious diseases. **<u>Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges</u>** Privileges include: • Management of an unusually severe infection such as tuberculosis, meningitis, disseminated tuberculosis, systemic mycosis, and unusual infections in the immune-compromised host • Management of investigational anti-infective agents • Lumbar puncture	Successful completion of an ACGME or AOA-accredited residency/fellowship in infectious disease or foreign equivalent training. **<u>AND Either</u>** Current certification or active participation in the examination process leading to certification in Infectious Disease 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 provision of inpatient or consultative services for inpatients or outpatients with infectious disease problems, 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	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 ** **	**Proctoring Requirements**
☐	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
☐	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	
☐	Treatment of patients in outpatient clinics at Stanford Hospital & Clinics	Must have teaching appointment through the Stanford School of Medicine.		
☐	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		
☐	HIV/AIDS Specialist	Board Certification or clinical experience. Must complete attached attestation.	_______# 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 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.

Practitioner HIV/AIDS Attestation

Return by Fax To: Fcxkf"I wgtpug{."EREU

Fax Number: 650-83: -: 828"Go ckn<"fi wgtpug{B uvcphqtf o gf 0qti

☐ No, I do not wish to be designated as a HIV/AIDS specialist.

☐ Yes, I do wish to be designated as a HIV/AIDS specialist based on the below criteria:

- ☐ I am credentialed as a "HIV Specialist" by the American Academy of HIV Medicine.

OR

- ☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV medicine by a member board of the American Board of Medical Specialties;

OR

- ☐ I am board certified in Infectious Disease and in the past 12 months have clinically managed at least 25 HIV patients and completed 15 hours of category 1 CME in HIV medicine, five hours of which was related to antiretroviral therapy;

OR

- ☐ In the past 24 months, I have provided clinical management to 20 HIV patients and in the past 12 months have completed board certification in Infectious Disease;

OR

- ☐ In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV medicine;

OR

- ☐ In the past 24 months I have clinically managed at least 20 HIV patients and in the past 12 months have completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required).

Physician's Name (Print) ______________________________________ Date: ________________

Signature (required) ______________________________________ License #_________________

Telephone #_______________________

Name and Title of Person Submitting Form____