



Privileges in Pediatric 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				
<input type="checkbox"/>	<p><u>Privileges included in the Core:</u> Privileges to admit, evaluate, diagnose, consult, perform history and physical exam, and provide treatment to pediatric patients, and perform procedures that are not life-threatening.</p> <p><u>Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges</u></p> <p>Core privileges include:</p> <ul style="list-style-type: none"> • venipuncture • laceration repair • incision and drainage of superficial abscesses • treatment of major complicated illnesses • eating disorders • lumbar puncture 	<p>Successful completion of an ACGME or AOA-accredited residency/fellowship in pediatrics or foreign equivalent training.</p> <p align="center"><u>AND Either</u></p> <p>Current certification or active participation in the examination process leading to certification in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or foreign equivalent training/board.</p> <p align="center"><u>OR</u></p> <p>Documentation or attestation of the management of at least 50 pediatric (0-18) inpatients or outpatients as the attending physician (or senior resident), at an accredited facility, during the past two years</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 –provider must meet with proctor to discuss completed cases/charts</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 – provider must meet with proctor to discuss completed cases/charts
<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"/>	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		
<input type="checkbox"/>	Cardiac catheterization	Must meet criteria for Pediatric Cardiology	_____ # of cases in 2 years	5 Chart Reviews – provider must meet with proctor to discuss completed cases/charts
<input type="checkbox"/>	Bone marrow aspiration, biopsy, or harvest	Must meet criteria for Pediatric Oncology	_____ # of cases in 2 years	5 Chart Reviews – provider must meet with proctor to discuss completed cases/charts

**** 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.