



<b>SPECIAL PRIVILEGES</b> (MUST ALSO MEET THE CRITERIA ABOVE)				
REQUESTED	PROCEDURE	ADDITIONAL CREDENTIALING CRITERIA (if applicable)	# 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"/>	Treatment of patients in outpatient clinics at Stanford Hospital & Clinics	Must have teaching appointment through the Stanford School of Medicine.		
<input type="checkbox"/>	Admit, treat, perform surgical procedures, or provide follow-up care for inpatients ages 14 years or younger	Must have membership and privileges at Lucile Packard Children's Hospital	_____ # of cases in 2 years	
<input type="checkbox"/>	Complex hand surgery		_____ # of cases in 2 years	5 chart reviews
<input type="checkbox"/>	Complex craniofacial surgery		_____ # of cases in 2 years	5 chart reviews
<input type="checkbox"/>	Use of surgical laser		_____ # 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.