



## Privileges in Trauma 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)
- 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	PROCOTORING REQUIREMENTS
<b>CORE PRIVILEGES</b>				
<input type="checkbox"/>	<p><b><u>Privileges included in the Core: **</u></b> Privileges to admit, evaluate, diagnose, consult, perform history and physical exam, and provide medical and surgical treatment to patients presenting with traumatic injuries.</p> <p><b><u>Cross out &amp; INITIAL any privilege/s you are not applying for in this set of Basic Privileges</u></b></p> <p>Core privileges include:</p> <ul style="list-style-type: none"> <li>• resuscitate and diagnose injuries in the trauma victim</li> <li>• intervene surgically after diagnostic studies are performed and coordinate care by subspecialty consultants</li> <li>• supervise/perform all necessary operative cases</li> <li>• manage the trauma patient throughout his/her stay in the acute-care facility as well as coordinate the early institution of rehabilitation and discharge planning</li> </ul>	<p>Successful completion of an ACGME or AOA-accredited residency in General Surgery or foreign equivalent training.</p> <p>Current certification in Advanced Trauma Life Support.</p> <p>Meet requirements as outlined by American College of Surgeon Committee on Trauma.</p>	<p>Appropriate number of cases performed per year as based on Category</p> <p>_____ # cases in the past 2 years</p>	<p>5 chart reviews</p>

<b>SPECIAL PRIVILEGES</b> (MUST ALSO MEET THE CRITERIA ABOVE)				
<b>REQUESTED</b>	<b>PROCEDURE</b>	<b>ADDITIONAL CREDENTIALING CRITERIA</b>	<b># of Cases performed in past 2 yrs **</b>	<b>PROCTORING REQUIREMENTS</b>
<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.	____ # cases in the past 2 years	5 chart reviews
<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	____ # cases in the past 2 years	

**\*\* 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.