Huntington Memorial Hospital

Delineation Of Privileges

Hematology/Medical Oncology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
HEMATOLOGY/MEDICAL ONCOLOGY PRIVILEGES			
Criteria: a) Board Certification by the American Board of Internal Medicine with Subspecialty Certificate in Hematology and/or Oncology; **OR** b) Successful completion of an ACGME or AOA approved training program in Hematology and/or Oncology.			
Proctoring Requirements: A minimum of eight (8) cases, in accordance with the Medical Staff Proctoring Protocol.			
GENERAL PRIVILEGES:	___	___	___
Admitting privileges	___	___	___
Consultation Only privileges	___	___	___
Sedation analgesia ***Criteria:*** Requires successful completion of the Sedation Assessment Test. ***Additional criteria effective April 1, 2015:*** a) Evidence of current ACLS and/or PALS certification from the American Heart Association; AND b) Evidence of completion of an Airway Management Course	___	___	___
a) Adult Sedation	___	___	___
b) Pediatric Sedation (17 years and under)	___	___	___
CORE HEMATOLOGY/MEDICAL ONCOLOGY PRIVILEGES: Includes the management and coordination of care, treatment and services, including: Medical history and physical examinations, consultations and prescribing medication according to DEA Certificate. (ACC)	___	___	___
Patient-controlled analgesia (PCA)	___	___	___
TPN Management	___	___	___
Fine Needle aspiration	___	___	___
Standard Chemotherapy:	___	___	___
a) Intrapleural therapy	___	___	___
b) Intraperitoneal therapy	___	___	___
c) Intrathecal therapy	___	___	___
d) Chemotherapy arterial/hepatic infusion	___	___	___
Chemotherapy via SQ access port	___	___	___
Lumbar puncture and accessing ommaya	___	___	___
Needle biopsy, bone marrow	___	___	___
Plasmapheresis	___	___	___
Investigational chemotherapy ***Criteria:*** Requires approval by the IRB.	___	___	___
SUPPLEMENTAL HEMATOLOGY/MEDICAL ONCOLOGY PRIVILEGES: Applicants must meet the criteria outlined for Core Hematology/Medical Oncology Privileges in addition to the specific criteria outlined under the supplemental privilege requested.			
Endotracheal tube placement ***Criteria:*** Requires current Advanced Cardiac Life Support (ACLS) certification.	___	___	___

Delineation Of Privileges

Hematology/Medical Oncology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Criteria: Must meet criteria outlined for Core Hematology/Medical Oncology privileges, as outlined above. ***Proctoring Requirement:*** A minimum of one (1) case to be proctored by direct observation for each supplemental privilege requested, unless waived by Section Chair/Department Chair. ***Competency Requirement:*** Must provide evidence of performing at least one (1) procedure over a two-year period for each of the supplemental privileges listed below, at this facility or another facility where privileges are held. In the event the competency requirement is not met, proctoring will be required on a minimum of one (1) case.	___	___	___
Paracentesis	___	___	___
Thoracentesis	___	___	___
Joint Aspiration and Injection	___	___	___

ACKNOWLEDGEMENT OF THE PRACTITIONER:
I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at Huntington Hospital, and I understand that: a) in exercising my clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation; b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature of Applicant: ____

Date: _______________________

DEPARTMENT CHAIR RECOMMENDATIONS

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Applicant may perform privileges and procedures as indicated:

________ YES ________ NO

Exceptions/Limitations (Please Specify):

____

APPROVALS:

Section Chair: ____ **Date:** _______________

Department Chair: _____________________________________ **Date:** ______________

Credential Committee Date: ___________

Medical Executive Committee Date: ___________

Board of Directors Approved on: ___________