

### **CRITERIA FOR GRANTING MEDICAL PRIVILEGES**

Please review these categories carefully to determine those privileges for which you are qualified. Indicate your request below by checking the appropriate category. If you feel that special training or experience qualifies you for advanced privileges, please contact the appropriate department chair.

I hereby request Category I, and/or II and/or Category III privileges within the scope of my training and experience. Any licensed physician on staff may render any care in a life threatening emergency.

**CATEGORY 1: GENERAL**

The following privileges require board certification or equivalent training in family practice or five years successful practice in family or general practice. Physician may admit, perform history & physicals and treat within their specialty. Consultation strongly suggested for any patient whose diagnosis or management remains in question for more than four days post admission, or for any patient with a life threatening condition.

**CATEGORY 2: GENERAL ADVANCED**

The following privileges require board certification or equivalent training or 5 years successful practice in internal medicine. Physician may admit, perform history & physicals and treat within their specialty. Consultation suggested for cases in which diagnosis or management remain in question for a longer than usual period of time. Consultation suggested if patient's condition is life threatening.

**CATEGORY 3: GENERAL ADVANCED – SUBSPECIALTY**

The following privileges require sub-specialty board certification or equivalent training or 5 years successful practice in this sub-specialty. Physician may admit, perform history & physicals and treat within their specialty. Consultation suggested for cases in which diagnosis or management remain in question for a longer than usual period of time. Consultation suggested if patient's condition is life threatening.

***PROCTORING REQUIREMENTS:*** *It is the responsibility of the physician doing the procedure to obtain proctor forms and to ensure that the proctoring report is forwarded to the Medical Staff Office. A physician will be removed from the proctoring program when the reports have been reviewed by the Medical Department and the physician is so notified. If, at the time of reappointment, certain procedures have not met the required number to be performed within the past two years, monitoring may be assigned.*

Foothill Presbyterian Hospital  
 Medical Privileges Request Form  
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After reading the “Criteria for Granting Medical Privileges” please circle the appropriate Category(s) and return to the Medical Staff Office.

<b><u>DISEASE CLASSIFICATION</u></b>	<b><u>CATEGORY REQUESTED</u></b>		
Allergy/Immunology	1	2	3
Cardiology	1	2	3
Dermatology	1	2	3
Endocrinology	1	2	3
Family/General Practice	1	2	3
Gastroenterology	1	2	3
Hematology	1	2	3
Infectious Disease	1	2	3
Internal Medicine	1	2	3
Neurology	1	2	3
Medical Oncology	1	2	3
Nephrology	1	2	3
Pulmonology	1	2	3
Physical/Rehab Medicine	1	2	3
Psychiatry	1	2	3
Rheumatology	1	2	3
Assist in Surgery (except cases that require add'l training/certification)			1

\_\_\_\_\_  
 Applicants Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Chair, Medical Department

\_\_\_\_\_  
 Date

FOOTHILL PRESBYTERIAN HOSPITAL  
Glendora, California 91741

## FAMILY PRACTICE/ GENERAL PRACTICE PRIVILEGES REQUEST FORM

Please check all categories and privileges for which you have adequate training or expertise.

Privileges: To admit, treat and perform history & physicals and consult with limitation.  
Consultation strongly suggested for any case in which diagnosis or management remain in question for a longer than usual period of time.

### SPECIAL PROCEDURES

<u>PRIVILEGES REQUESTED</u>	<u>APPROX. # PERFORMED LAST 2 YEARS</u>	<u>APPROVED AND/OR COMMENTS</u>
<b><u>BIOPSY</u></b>		

<input type="checkbox"/> SKIN	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> LYMPH NODE	<input type="checkbox"/>	<input type="checkbox"/>

<b><u>ENDOSCOPY - BIOPSY</u></b>
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<input type="checkbox"/> SIGMODIOSCOPY - RIGID	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> SIGMODIOSCOPY - FLEXIBLE	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ANOSCOPY	<input type="checkbox"/>	<input type="checkbox"/>

<b><u>ASPIRATION(S)</u></b>
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<input type="checkbox"/> JOINT	<input type="checkbox"/>	<input type="checkbox"/>
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<b><u>OTHER</u></b>
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<input type="checkbox"/> PERIPHERAL ARTERIAL PUNCTURE	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> LUMBAR PUNCTURE	<input type="checkbox"/>	<input type="checkbox"/>

On the basis of my training and experience, I am qualified to exercise and request the privileges which I have checked.

**PRIVILEGES APPROVED:**  AS REQUESTED  AS MODIFIED \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature Date

\_\_\_\_\_  
Chair, Medical Department Date

**FAMILY PRACTICE/GENERAL PRACTICE  
 GENERAL SURGERY PRIVILEGES REQUEST FORM**  
 (Minor surgical privileges that can be acceptably requested by a family or general  
 practitioner with adequate documentation.)

ALL PHYSICIANS OR SURGEONS APPLYING FOR MAJOR SURGICAL PRIVILEGES NEED TO BE OR  
 FORMALLY HAVE BEEN BOARD ELIGIBLE OR BOARD CERTIFIED IN A SURGICAL SPECIALTY

<u>PRIVILEGES REQUESTED</u>	<u>APPROX. # PERFORMED LAST 2 YEARS</u>	<u>APPROVED AND/OR COMMENTS</u>
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<b><u>GENERAL SURGERY/UROLOGY</u></b>
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_____ REPAIR SKIN LACERATIONS	_____	_____
_____ SKIN & SUBCUTANEOUS BIOPSY	_____	_____
_____ INCISION & DRAINAGE SUPERFICIAL ABCESS	_____	_____
_____ PARACENTESIS	_____	_____
_____ I & D PERIANAL ABSCESS	_____	_____
_____ VASECTOMY	_____	_____
_____ CIRCUMCISION	_____	_____

<b><u>ENT</u></b>
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_____ REPAIR SIMPLE SKIN LACERATIONS	_____	_____
_____ EXCISION SKIN LESIONS/ SM ORAL LESIONS	_____	_____
_____ I & D OF SMALL FACIAL ABSCESS	_____	_____
_____ SECOND DEGREE BURNS - FACE	_____	_____

<b><u>OB/GYN</u></b>
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_____ I & D OF BARTHOLIN ABSCESSSES (GYN ORIENTED)	_____	_____
_____ BIOPSY - VULVA	_____	_____
_____ BIOPSY - CERVIX	_____	_____
_____ EPISIOTOMY (FOR EMERG DELIVERY)	_____	_____
_____ REMOVAL OF FOREIGN BODY	_____	_____

**PRIVILEGES  
REQUESTED**

**APPROX #  
PERFORMED  
LAST 2 YEARS**

**APPROVED  
AND/OR  
COMMENTS**

**OPHTHALMOLOGY**

\_\_\_\_\_ CHALAZION

\_\_\_\_\_

\_\_\_\_\_

**ORTHOPEDIC SURGERY**

\_\_\_\_\_ APPLICATION OF SPLINT OR CAST (NON-  
DISPL FRACTURES AND/OR SPRAINS

\_\_\_\_\_

\_\_\_\_\_

On the basis of my training and experience, I am qualified to exercise and request the privileges which I have checked.

I have not requested privileges for any procedures for which I am not qualified. I am familiar with the laws of the State governing the practice of medicine and pledge to abide by these laws.

**PRIVILEGES APPROVED: [ ] AS REQUESTED [ ] AS MODIFIED BELOW**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chair, Surgery Department

\_\_\_\_\_  
Date

## FAMILY PRACTICE/ GENERAL PRACTICE PEDIATRIC PRIVILEGES REQUEST FORM

Please check all categories and privileges for which you have adequate training or expertise.

Privileges: To admit, treat, perform history & physicals and consult with limitation. Consultation strongly suggested for any case in which diagnosis or management remain in question for a longer than usual period of time.

### I. PEDIATRIC PRIVILEGES

Privileges to perform emergency lifesaving procedures are automatically granted to all Medical Staff physicians.

<u>PRIVILEGES REQUESTED</u>	<u>APPROX. # PERFORMED LAST 2 YEARS</u>	<u>APPROVED AND/OR COMMENTS</u>
_____ NEONATAL CIRCUMCISION	_____	_____
_____ SIMPLE FRACTURE AND DISLOCATIONS	_____	_____

### IV. DIAGNOSTIC PROCEDURES

<u>PRIVILEGES REQUESTED</u>	<u>APPROX # PERFORMED LAST 2 YEARS</u>	<u>APPROVED AND/OR COMMENTS</u>
_____ LUMBAR PUNCTURE	_____	_____
_____ NEONATAL	_____	_____
_____ PEDIATRIC	_____	_____
_____ ADOLESCENT	_____	_____

**PRIVILEGES APPROVED:** [  ] AS REQUESTED [  ] AS MODIFIED \_\_\_\_\_

\_\_\_\_\_  
 Applicant's Signature Date

\_\_\_\_\_  
 Chair, Pediatrics Department Date