FOOTHILL PRESBYTERIAN HOSPITAL
An Affiliate of Citrus Valley Health Partners

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.*

After reading the "Criteria for Granting Medical Privileges" please circle the appropriate Category(s) and return to the Medical Staff Office.

DISEASE CLASSIFICATION	**CATEGORY REQUESTED**		
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

_____ _____
Applicants Signature Date

_____ _____
Chair, Medical Department Date

Name:**_____**

Appointment: **A minimum of three (3)** cases of any of the following elective procedures **MUST** be proctored by a member of the Active Staff who has been granted the privilege.

Reappointment: **A minimum of three (3)** cases of any of the following elective procedures **MUST** be performed within the past two years. If this is not met, the request will be evaluated and monitoring may be re-assigned.

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	GENERAL INTERNAL MEDICINE	APPROVED	DENIED
☐	_____	Anoscopy	☐	☐
☐	_____	Arterial Puncture	☐	☐
☐	_____	EKG	☐	☐
☐	_____	Intubation	☐	☐
☐	_____	Joint Aspiration	☐	☐
☐	_____	Lumbar Puncture	☐	☐
☐	_____	Paracentesis	☐	☐
☐	_____	Proctoscopy, rigid	☐	☐
☐	_____	Sigmoidoscopy	☐	☐
☐	_____	Stress Test (Treadmill)	☐	☐
☐	_____	Subclavian Catheter	☐	☐
☐	_____	Thoracentesis	☐	☐
☐	_____	TPN	☐	☐

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	CARDIOLOGY	APPROVED	DENIED
☐	_____	Elective cardioversion	☐	☐
☐	_____	Echocardiograph interpretation	☐	☐
☐	_____	Holter Monitor interpretation	☐	☐
☐	_____	Pericardiocentesis	☐	☐
☐	_____	Stress electrocardiogram	☐	☐
☐	_____	Subclavian Catheter	☐	☐
☐	_____	Right Heart – Swan Ganz	☐	☐
☐	_____	Atrial CVP Catheter	☐	☐
☐	_____	Intra-Arterial Line	☐	☐
☐	_____	Arterial Puncture	☐	☐
☐	_____	Thrombolytic Therapy	☐	☐
☐	_____	Dobutamine/Persantine Stress Test with Nuclear Medicine	☐	☐
☐	_____	Carotid Vascular Profile	☐	☐
☐	_____	Venous Duplex Scan Extremities	☐	☐
☐	_____	Arterial Duplex Scan Extremities	☐	☐

(REQUIRES CURRENT FLUOROSCOPY)

☐	_____	Pacemaker, temporary transvenous	☐	☐
☐	_____	Pacemaker, permanent transvenous	☐	☐

Name:_____

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	DERMATOLOGY	APPROVED	DENIED
☐	_____	Dermatologic Cryotherapy	☐	☐
☐	_____	Electrodesiccation/Curettage	☐	☐
☐	_____	Excisional Skin Biopsy under local anesthesia	☐	☐
☐	_____	Laser for cutaneous lesions (documentation of having taken an approved course in laser therapy must be submitted)	☐	☐
☐	_____	Skin Surgery Excision of cancer _____Facial _____Non-facial _____plastic repair	☐	☐
☐	_____	Lymph node excision (Region:_____)	☐	☐

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	ENDOCRINOLOGY	APPROVED	DENIED
☐	_____	Open/Closed Loop Insulin Infusion Device	☐	☐
☐	_____	Thyroid Biopsy	☐	☐

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	GASTROENTEROLOGY	APPROVED	DENIED
☐	_____	Colonscopy	☐	☐
☐	_____	Colonscopy with Polypectomy	☐	☐
☐	_____	EGD – Esophagogastroduodenoscopy	☐	☐
☐	_____	ERCP-Endoscopic retrograde cholangiopancreatography- with or without endoscopic papillotomy	☐	☐
☐	_____	Esophageal Dilitation	☐	☐
☐	_____	- Bouginage	☐	☐
☐	_____	- Wire Guided	☐	☐
☐	_____	- Pneumatic	☐	☐
☐	_____	Flexible Sigmoidscopy	☐	☐
☐	_____	with Biopsy	☐	☐
☐	_____	with Polypectomy	☐	☐
☐	_____	Percutaneous Liver Biopsy	☐	☐
☐	_____	Sclerotherapy	☐	☐
☐	_____	Band Ligation	☐	☐

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	HEMATOLOGY/ ONCOLOGY	APPROVED	DENIED
☐	_____	Bone Marrow Aspiration	☐	☐
☐	_____	Bone Marrow Biopsy	☐	☐
☐	_____	Cancer Chemotherapy	☐	☐

*Name:*_____

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	NEPHROLOGY	APPROVED	DENIED
☐	_____	Hemodialysis	☐	☐
☐	_____	Percutaneous Renal Biopsy	☐	☐
☐	_____	Peritoneal Dialysis	☐	☐

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	NEUROLOGY	APPROVED	DENIED
☐	_____	CVP	☐	☐
☐	_____	Electroencephalography	☐	☐
☐	_____	Electromyography	☐	☐
☐	_____	Nerve Conduction Study	☐	☐

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	PSYCHIATRY	APPROVED	DENIED
☐	_____	Psychiatric Evaluation	☐	☐
☐	_____	Psychotherapy	☐	☐
☐	_____	Detoxification (alcohol or drugs)	☐	☐

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	PULMONOLOGY	APPROVED	DENIED
☐	_____	Arterial Blood Gases	☐	☐
☐	_____	Bronchoscopy	☐	☐
☐	_____	Bronchoscopy with trans-	☐	☐
		bronchial biopsy	☐	☐
☐	_____	Laryngoscopy	☐	☐
☐	_____	Lung Biopsy	☐	☐
☐	_____	Mechanical Ventilator Mgmt	☐	☐
☐	_____	PFT	☐	☐
☐	_____	Pleurodesis	☐	☐
☐	_____	Transtracheal Aspiration	☐	☐
☐	_____	Tube Thoracotomy (chest tube)	☐	☐
☐	_____	Transthoracic Needle Biopsy (Lung or Pleura)	☐	☐
☐	_____	Thoracentesis	☐	☐

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	RHEUMATOLOGY	APPROVED	DENIED
☐	_____	Joint Aspiration or Injection	☐	☐
☐	_____	Percutaneous Synovial Biopsy	☐	☐

_____ _____

SIGNATURE OF APPLICANT DATE

_____ _____

CHAIR, MEDICAL DEPARTMENT DATE

Medicine
2/99, 5/04, 8/07, 6/09, 1/2010

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PROCEDURAL SEDATION PRIVILEGES

Procedural Sedation: Minimal, Moderate or Deep Sedation (with or without analgesia) for the purpose of performing a diagnostic or therapeutic procedure, for which there is a reasonable expectation that in the manner used, the sedation/analgesia will result in the loss of protective reflexes for a significant percentage or a group of patients.

NAME:_____

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	PROCEDURAL SEDATION	APPROVED (to be marked by Anesthesia Chief)	DENIED
☐	_____	Sedation Analgesia *(Requires successful completion of written examination*	☐	☐
☐	_____	**ADULT**		
	☐	Meperidine (Demerol)	☐	☐
	☐	Morphine	☐	☐
	☐	Diazepam (Valium)	☐	☐
	☐	Midazolam (Versed)	☐	☐
	☐	Brevital	☐	☐
	☐	Sublimaze (Fentanyl)	☐	☐
	☐	Librium (12 years and older)	☐	☐
	☐	Ativan	☐	☐
	☐	Propofol	☐	☐
	☐	Etomidate	☐	☐
☐	_____	**PEDIATRICS**	☐	☐
	☐	Versed	☐	☐
	☐	Valium	☐	☐
	☐	Fentanyl	☐	☐
	☐	Demerol	☐	☐
	☐	Ketamine	☐	☐

_____ _____
SIGNATURE OF APPLICANT DATE

_____ _____
ANESTHESIA DIRECTOR DATE

cspriv 2/01, 7/02, 4/04, 5/05, 5/06, 7/09