

CRITERIA FOR GRANTING PATHOLOGY 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 Surgery Department chair and the Pathology Director.

MINIMAL FORMAL TRAINING REQUIREMENTS:

Physicians requesting privileges should have successfully completed an approved Pathology Residency Program (of their specialty) and be board certified or eligible.

PROCTORING REQUIREMENTS: *In accordance with the Medical Staff Bylaws and the requirements of the Joint Commission on Accreditation of Healthcare Organizations, each new applicant and reappointee (asking for new privileges) to the medical staff of Foothill Presbyterian Hospital must have a minimum of 20 cases proctored. Twenty must be proctored by an Active or Courtesy staff member of the surgery department. .*

We will appreciate your assistance and cooperation in ensuring that this is accomplished. To assist us, we are requesting that for your first 20 cases or until otherwise notified, you obtain a proctor for your surgical cases. Your proctor is named in your "Welcome to the Staff" letter.

The proctored cases should be representative of the privileges you are requesting in your specialty.

Upon completion of the required number of proctored cases, the surgery department will review and evaluate these reports. You will be advised of the decision regarding your satisfactory completion of proctoring or if there will need to be additional proctoring requirements. We are sure you understand the need to require your cooperation in these efforts. These are not only mandated requirements, but they are essential to the maintenance of the quality of care established by the medical staff at Foothill Presbyterian Hospital. Again, we appreciate your assistance in this matter.

If you have any questions regarding these proctoring requirements, please do not hesitate to contact the Medical Staff office at (626) 857-3241.

We welcome you.

Name: _____

Appointment/Reappointment: 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	AUTOPSY PATHOLOGY PRIVILEGES	APPROVED	DENIED
<input type="checkbox"/>	_____	Post Mortem Procedures and Interpretations	<input type="checkbox"/>	<input type="checkbox"/>

REQUESTED	# PERFORMED IN LAST 2 YEARS	SURGICAL PATHOLOGY	APPROVED	DENIED
<input type="checkbox"/>	_____	Rapid Frozen Section Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Operating Room Consultation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Diagnosis-Micro. findings Histologic Sections	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Evaluation Cytological Preparations	<input type="checkbox"/>	<input type="checkbox"/>

REQUESTED	# PERFORMED IN LAST 2 YEARS	BONE MARROW	APPROVED	DENIED
<input type="checkbox"/>	_____	Biopsy and/or Aspiration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Interpretation	<input type="checkbox"/>	<input type="checkbox"/>

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

REQUESTED	# PERFORMED IN LAST 2 YEARS	CLINICAL CHEMISTRY CONSULTATION & CORRELATION/LABORATORY QUALITY EVALUATION	APPROVED	DENIED
<input type="checkbox"/>	_____	Consult-All Areas of Chemistry and Special Chemistry	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Interpret Tests & Correlation w/Clinical Findings	<input type="checkbox"/>	<input type="checkbox"/>

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

REQUESTED	# PERFORMED IN LAST 2 YEARS	HEMATOLOGY	APPROVED	DENIED
<input type="checkbox"/>	_____	Consult-All Areas Dx. Hematology	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Consult-All Coagulopathies	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Consult-Whole Blood & Blood Component Therapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Investigation Transfusion Reaction	<input type="checkbox"/>	<input type="checkbox"/>

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

REQUESTED	# PERFORMED IN LAST 2 YEARS	MICROBIOLOGY	APPROVED	DENIED
<input type="checkbox"/>	_____	Consult-All areas of Microbiology	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Consult-All phases of Infection	<input type="checkbox"/>	<input type="checkbox"/>

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

REQUESTED	# PERFORMED IN LAST 2 YEARS	OTHER PRIVILEGES OF CONSULTATION	APPROVED	DENIED
<input type="checkbox"/>	_____	Immunology Tests	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Parasitology Tests	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Blood Banking	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Serological Tests	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Molecular Pathology Tests	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Genetic Tests	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Clinical Microscopy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>

I certify that I have had the necessary training and experience to perform the procedures that I have requested. All privileges delineated have been individually considered and have been recommended based upon practitioner's specialty, licensure, specific training, experience, health status, current competency and peer recommendations.

PRIVILEGES APPROVED: AS REQUESTED AS MODIFIED BELOW

 SIGNATURE OF APPLICANT

 DATE

 CHAIR, SURGERY DEPARTMENT

 DATE

fphpath
 10/09, 1/2010