

Regions Hospital Delineation of Privileges Allergy and Immunology

Applicant's Name: _____
Last
First
M
Date

Instructions: Applicants must provide complete names and addresses for their references. **Please DO NOT SEND letters of recommendation along with your application.** These must be primary source verified by Regions Hospital. If documentation of cases or procedures is required, please attach case and/or procedural logs to your privilege delineation.

CORE I- General Privileges Allergy and Immunology

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include being able to admit, work up and provide non-surgical therapy to patients presenting with allergic or immunology conditions, including the provision of consultation.</p>	<ol style="list-style-type: none"> 1. MD, DO, MBBS 2. Successful completion of an ACGME AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency training program in Internal Medicine or Pediatrics followed by at least two years of approved residency or fellowship in allergy and immunology, or completion of an approved ACGME AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency program in Internal Medicine, Pediatrics, or Family Practice providing that such residency included a minimum of six months' training in Pediatrics and Adult Allergy and Immunology. 	<p><u>New Applicants:</u> Evaluation of your competency by an allergy/immunology physician. Please indicate name and address of the physician whom we may contact.</p> <p>Name: _____ Name of Facility _____ Add: _____ Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> 1. Documentation of number of inpatient services performed during the past 24 months, or 2. Evaluation of your competency by a peer of your choice. Please indicate name and address of the physician whom we may contact. <p>Name: _____ Name of Facility _____ Add: _____ Ph/Fax: _____</p>

TO BE COMPLETED BY APPLICANT:

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges will not proceed until which time that the information is received.

Signature

Date

TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL:

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

Signature

Date