

# *Regions Hospital*

## *Delineation of Privileges*

### *Physiatry (Physical Medicine and Rehabilitation)*

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 Physiatry (PM&R)**

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include being able to admit, work-up and provide nonsurgical therapeutic treatment to patients presenting with neuromuscular disorders, musculoskeletal disorders, or other medical disorders commonly treated by Physician Medicine and Rehabilitation specialists. This also includes the provision of consultation. These privileges do not include any of the special requests listed under the section entitled "Special Requests for Privileges in Physical Medicine and Rehabilitation".</p>	<ol style="list-style-type: none"> <li>1. MD, DO, MBBS</li> <li>2. Successful completion of an ACGME or AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency training program in PM&amp;R, or</li> <li>3. Currently enrolled in an ACGME or AOA approved residency training program in PM&amp;R, or</li> <li>4. Board certified or eligible and progressing toward board certification in PM&amp;R.</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Name and address of the person responsible for the applicant's residency training, <b>or</b></li> <li>2. The PM&amp;R department chief of another hospital that applicant has been affiliated with for the past 2 years, <b>and</b></li> <li>3. Name and address of a primary care physician <b>and</b> a PM&amp;R specialist who can comment on the applicant's current clinical competency in the field of PM&amp;R.</li> </ol> <p>Name: _____            Name of Facility: _____            Add: _____            Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Documentation of the provision of inpatient or consultation services to at least 40 patients in the last 24 months or the clinical equivalent, or</li> <li>2. Successful completion of recertification testing per the American Board of PM&amp;R as appropriate.</li> <li>3. Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact.</li> </ol> <p>Name: _____            Name of Facility: _____            Add: _____            Ph/Fax: _____</p>

**CORE II- Special Privileges Psychiatry (PM&R)**

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
<input type="checkbox"/> Electrodiagnostic Procedures	<ol style="list-style-type: none"> <li>1. MD, DO</li> <li>2. Successful completion of an ACGME or AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved PM&amp;R residency training program.</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Documentation of completion of an EMG fellowship or course in EMG, <b>or</b></li> <li>2. Name and address of residency Director whom we may contact who can document previous experience in EMG, <b>or</b></li> <li>3. Demonstrated competency to Regions Hospital Medical Director of PM&amp;R.</li> </ol> <p>Name: _____            Name of Facility: _____            Add: _____            Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Documentation of performing 20 EMG procedures within the past 24 months.</li> </ol>
<input type="checkbox"/> Nerve Blocks	<ol style="list-style-type: none"> <li>1. MD, DO</li> <li>2. Successful completion of an ACGME or AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved PM&amp;R residency training program.</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Documentation of course on nerve block, <b>or</b></li> <li>2. Name and address of residency Director whom we may contact who can document previous experience in nerve block, <b>or</b></li> <li>3. Demonstrated competency to Regions Hospital Medical Director of PM&amp;R.</li> </ol> <p>Name: _____            Name of Facility: _____            Add: _____            Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Documentation of performing 20 nerve block procedures within the past 24 months.</li> </ol>
<input type="checkbox"/> Motor Point Blocks	<ol style="list-style-type: none"> <li>1. MD, DO</li> <li>2. Successful completion of an ACGME or AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved PM&amp;R residency training program.</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Documentation of motor point course, <b>or</b></li> <li>2. Name and address of residency Director whom we may contact who can document previous experience in motor point, <b>or</b></li> <li>3. Demonstrated competency to Regions Hospital Medical Director of PM&amp;R.</li> </ol> <p>Name: _____            Name of Facility: _____            Add: _____            Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> <li>2. Documentation of performing 20 motor point procedures within the past 24 months.</li> </ol>

**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