

# *Regions Hospital*

## *Delineation of Privileges*

### *Dermatology*

**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 Dermatology**

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
Constitute the scope of care of a fully trained physician with current certification by the American Board of Dermatology, development of diagnosis and treatment plan for inpatient and outpatients, appropriate utilization of medication, diagnosis skin/oral/genital biopsies, KOH/scabies. Tzanck preps, tissue cultures, cutaneous surgical excisions site by simple, intermediate or complex repair, repair of cutaneous excision site by flaps and grafts, cryotherapy/cryosurgery, electrodesiccation and curettage, ultraviolet light therapy, patch testing, photodynamic therapy and chemical peels.	<ol style="list-style-type: none"> <li>1. M.D. or D.O., MBBS <b>AND</b></li> <li>2. Successful completion of an ACGME AOA, Royal College of Physicians and Surgeons of Canada approved residency program in Dermatology</li> </ol>	<p><b><u>New Applicants:</u></b>            Documentation of current board certification or eligibility by the American Board of Dermatology and if within 2 years of completion of residency, please indicate name and address of the <u>Residency Training Program Director</u> whom we may contact, who can attest to your current clinical competence to perform the requested privileges.</p> <p>Name: _____            Name of Facility: _____            Address: _____            Ph/Fax# _____</p> <p>If more than 2 years beyond completion of residency, please provide the names of two physician peers who we may contact to attest to your current clinical competence:</p> <p>Name: _____            Name of Facility: _____            Address: _____            Ph/Fax: _____</p> <p>Name: _____            Name of Facility: _____            Address: _____            Ph/Fax: _____</p> <p><b><u>Reappointment Applicants:</u></b>            Documentation of current board certification and evaluation of your competency conducted by a qualified peer of your choice.</p> <p>Please indicate name and address of a qualified physician peer whom we may contact.</p> <p>Name: _____            Name of Facility: _____            Address: _____            Ph/Fax: _____</p>

**CORE II- Special Privileges Dermatology**

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
<input type="checkbox"/> Mohs' Micrographic Surgery	<ol style="list-style-type: none"> <li>1. Same criteria as Core I privileges; <b>AND</b></li> <li>2. Documented formal training in Mohs' Micrographic Surgery.</li> </ol>	<p><b><u>New Applicants:</u></b> Documentation of completion of the Mohs micrographic surgery training program by Director or equivalent or a peer who can attest to your clinical competence.</p> <p><b><u>Reappointment Applicants:</u></b> 1) Documentation of providing Mohs' Micrographic Surgery to patients on an ongoing basis; <b>AND</b> 2) Documentation of CME in the subject of Mohs' Micrographic Surgery.</p>
<input type="checkbox"/> Dermatopathology	<ol style="list-style-type: none"> <li>1. Same criteria as Core I privileges; <b>AND</b></li> <li>2. Documentation of successful completion of a dermatopathology fellowship.</li> </ol>	<p><b><u>New Applicants:</u></b> 1) Documentation from the program director of the Dermatopathology fellowship program is required or from a physician peer whom we may contact and who can attest to your clinical competence in Dermatopathology and 2) Board Certification in Dermatopathology by the American Board of Dermatology and Pathology.</p> <p><b><u>Reappointment Applicants:</u></b> 1) Documentation of the practice of dermatopathology on an ongoing basis, <b>AND</b> 2) Documentation of CME in the field of dermatopathology.</p>
<p>Other Procedures (check all that apply):</p> <input type="checkbox"/> Lasers (please specify) _____ _____	<ol style="list-style-type: none"> <li>1. Same criteria as Core I privileges; <b>AND</b></li> <li>3. Demonstration of documented competence by completion of a residency or fellowship training or through training courses.</li> </ol>	<p><b><u>New Applicants:</u></b> Documentation of appropriate training in the requested privileges.</p> <p><b><u>Reappointment Applicants:</u></b> 1) Documentation of the practice of requested special procedures on an ongoing basis <b>AND</b> 2) Documentation of CME in the field of the requested special procedures.</p>
<input type="checkbox"/> Collagen/fat/other injections <input type="checkbox"/> Sclerotherapy <input type="checkbox"/> Botox Injections <input type="checkbox"/> Hair Transplantation <input type="checkbox"/> Liposuction <input type="checkbox"/> Special cosmetic procedures (list) _____ _____		

**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. If the information is not received within the allowable timeframe as outlined within the Medical Staff Credentialing Policies & Procedures, I understand that the process will be stopped until such time that I submit the required documentation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY DIVISION/SECTION HEAD:**

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