

***Regions Hospital  
Delineation of Privileges  
Internal Medicine***

Applicant's Name: \_\_\_\_\_  
Last
First
Middle
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 Non-Staff Privileges Internal Medicine  
(Designated for Moonlighters)**

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include with appropriate consultation by a physician with Core II privileges, admission, work-up, diagnosis, and provision of non-surgical treatment including consultation for patients 16 years and above admitted or in need of care to treat general medical problems. These privileges do not include the special requests located on the following pages.</p>	<p>M.D., D.O., MBBS <u>and</u>             Currently enrolled in an ACGME, AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved Internal Medicine or Internal Medicine/Pediatric residency program.</p>	<p><u>New Applicants:</u>            Two (2) letters of reference from physicians who are not peers, who can comment on your current clinical competence. Please indicate names and addresses of the physicians whom we may contact.</p> <p>Name: _____            Name of Facility: _____            Address: _____            Fax/Phone: _____</p> <p>Name: _____            Name of Facility: _____            Address: _____            Fax/Phone: _____</p>

**CORE II – General Staff Privileges Internal Medicine**

Privileges	Basic Education & Minimal Formal Education	Required Documentation & Experience
<p>Privileges include admission, work-up, diagnosis and provision of non-surgical treatment including consultation for patients 16 years and above admitted or in need of care to treat general medical problems. These privileges do not include the special requests located on the following pages.</p>	<p>M.D. or D.O., MBBS <b>and</b>            Completion an ACGME, AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved Internal Medicine or Internal Medicine/Pediatric residency program.</p>	<p><u>New Applicants:</u>            Verification of competency from the residency program director or designee, <b>or</b>            Documentation of inpatient service to at least 30 patients in the past 12 months, <b>or</b>            Two (2) letters of reference from physician peers who can comment on your current clinical competence. Please indicate names and addresses of the physicians who we may contact.</p> <p>Name: _____            Name of Facility: _____            Address: _____            Fax/Phone: _____</p> <p>Name: _____            Name of Facility: _____            Address: _____            Fax/Phone: _____</p> <p><u>Reappointment Applicants:</u>            Must supply documentation of number of inpatient services performed during the past 24 months, <b>or</b>            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.</p> <p>Name: _____            Name of Facility: _____            Address: _____            Fax/Phone: _____</p>

**CORE III – Special Privileges Internal Medicine**

Privileges	Basic Education & Minimal Formal Education	Required Documentation & Experience
<input type="checkbox"/> Routine Management of Mechanical Ventilator  <input type="checkbox"/> Swan-Ganz  <input type="checkbox"/> Flexible Sigmoidoscopy  <input type="checkbox"/> Central Line Placement	Same criteria as outlined in Core I privileges.	<p><u>New Applicants:</u>            Verification of competency from the residency program director or designee, <b>or</b></p> <p>Documentation of number of procedures performed within the past 12 months, <b>or</b></p> <p>One (1) letter of reference from physician trained in the privilege area that can comment on your current competency to perform the procedure(s) requested. Please indicate name and address of the physician whom we may contact.</p> <p>Name: _____            Name of Facility: _____            Address: _____            Fax/Phone: _____</p> <p>Name: _____            Name of Facility: _____            Address: _____            Fax/Phone: _____</p> <p><u>Reappointment Applicants:</u>            Same criteria as outlined in Core II.</p> <p>Name: _____            Name of Facility: _____            Address: _____            Fax/Phone: _____</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. If the information is not received within the allowable timeframe as outlined within the Medical Staff Credentialing Policies and Procedures, I understand that the process will be stopped until such time that I submit the require documentation.

\_\_\_\_\_  
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

# *Regions Hospital Delineation of Privileges Conscious Sedation*

Applicant's Name: \_\_\_\_\_  
Last
First
M
Date

**Instructions:** In order to be eligible to request clinical privileges to administer conscious sedation, a practitioner's must meet the following basic education & minimal formal training and the requirement documentation and experience.

**Conscious Sedation**

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include being able to administer and manage moderate sedation/analgesia (Conscious Sedation): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accomplished by light tactile stimulation. A patent airway is maintained and spontaneous ventilation is adequate. Cardiovascular function is always maintained.</p>	<ol style="list-style-type: none"> <li>1. MD, DO, MBBS, DPM, DMD, DDS,</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.</li> </ol>	<p><u>Initial Applicants:</u></p> <ol style="list-style-type: none"> <li>1. All applicants must be able to demonstrate competence for moderate sedation/analgesia (i.e. conscious sedation) must have the skills to rescue patients who enter a state of deep sedation/analgesia.</li> <li>2. Each member applying for conscious sedation privileges will be required to document successful completion of an examination, provided by the medical staff services @ Regions at initial appointment or provide evidence of experience by meeting one of the following: <ul style="list-style-type: none"> <li>• Copy of test and passing score from another hospital</li> <li>• Copy of governing board letter indicating the applicant has conscious sedation privileges at another hospital</li> <li>• Letter from Medical Staff Office at another hospital indicating specifically that the practitioner has conscious sedation privileges and the date they were granted</li> <li>• Recent graduates must provide attestation of competency from their program director</li> </ul> </li> </ol>

		<p><b><u>Reappointment Application:</u></b></p> <ul style="list-style-type: none"> <li>• Successful applicant must be able to demonstrate that he/she has performed procedural sedation for at least ten (10) patients during the past twenty-four (24) months</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• documentation from his/her Division/Section Head of ongoing current competence</li> </ul>
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**TO BE COMPLETED BY APPLICANT:**

I understand that in making this request I am bound by the applicable Bylaws and policies of the Hospital and hereby stipulate that I meet the minimum threshold criteria for this request.

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.

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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.

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Signature \_\_\_\_\_ Date \_\_\_\_\_