

Regions Hospital

Delineation of Privileges

Neurology

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 Neurology

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges in Neurology include being able to admit, work-up and provide neurological diagnosis and therapy to patients presenting with illnesses of the central and or peripheral nervous system including neuromuscular function and muscle disease. These privileges do not include any of the special requests listed on the following pages.</p>	<ol style="list-style-type: none"> 1. MD, DO, MBBS 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 Neurology. 3. Board certification or progressing toward board certification in Neurology. 	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> 1. Documentation of inpatient neurological services to at least 24 patients during the past 12 months, or 2. Please indicate name and address of the Director of Neurology at facility where physician is currently practicing, or 3. Name and address of Residency Director if applicant is a new graduate of an accredited Residency program. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____ 4. Please indicate name and address of a Neurologist practicing in the community who can attest to your competency. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____ <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> 1. Documentation of Neurological services to at least 50 patients during the past 24 months, or 2. 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. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____

Core II- General Privileges Neurophysiologist

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>The neurophysiologist shall demonstrate the ability to select the appropriate modalities to effectively monitor the patient's neurophysiological status within the operating room.</p>	<p>1. Board certified or board eligible by the American Board of Neurophysiological Monitoring (ABNM).</p>	<p><u>New Applicants:</u> Please indicate name and address of Two (2) Neurologist's practicing in the community whom we may contact who can attest to your competency. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</p> <p>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u> 1. 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. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</p>

CORE III- Special Privileges Neurology

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p><input type="checkbox"/> Autonomic Testing</p> <p><input type="checkbox"/> EEG</p> <p><input type="checkbox"/> EMG and Nerve Conduction Velocity</p> <p><input type="checkbox"/> Somatosensory Evoked Responses</p> <p><input type="checkbox"/> Auditory Evoked Responses</p> <p><input type="checkbox"/> Visual Evoked Responses</p>	<p>1. MD, DO, MBBS</p> <p>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 Neurology.</p> <p>3. Board certified in Neurology.</p> <p>4. Completion of fellowship in Neuromuscular Disorders, or</p> <p>5. Board Certified or Board Eligible by the American Board of Neurophysiological Monitoring (ABNM).</p>	<p><u>New Applicants:</u> 1. Documentation of number of procedures performed during the past 12 months, or 2. Please indicate the names and addresses of two (2) Neurologists trained in the procedure(s), who can attest to your competency to perform the procedures requested. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u> 1. Documentation of number of procedures performed during the past 24 months, or 2. 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. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</p>

Special Privileges Neurology (Continued):

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
<input type="checkbox"/> Muscle Biopsy <input type="checkbox"/> Peripheral Nerve Biopsy	<ol style="list-style-type: none"> 1. MD, DO, MBBS 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 Neurology. 3. Board certified in Neurology. 4. Completion of fellowship in Neuromuscular Disorders. 	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> 1. Documentation of number of procedures performed during the past 12 months, or 2. Please indicate names and addresses of Two (2) Neurologists trained in the procedure(s) whom we may contact to attest to your competency to perform the procedures requested. <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 procedures performed during the past 24 months, or 2. 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>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</p>
<input type="checkbox"/> Noninvasive Intracranial and Extracranial Vascular Study <input type="checkbox"/> Transcranial Doppler	<ol style="list-style-type: none"> 1. MD, DO, MBBS 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 Neurology. 3. Board certified in Neurology. 4. Completion of fellowship in Neurodiagnostic imaging or Neuroradiology. 	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> 1. Documentation of number of procedures performed during the past 12 months, or 2. Please indicate the name and address of Two (2) Neurologists trained in the procedure(s) whom we may contact to attest to your competency to perform the procedures requested. <p>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</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 procedures performed during the past 24 months, or 2. 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>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</p>

Special Privileges Neurology (Continued):

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
<input type="checkbox"/> Transcutaneous Angiography of Cerebral Vessels	<ol style="list-style-type: none"> 1. MD, DO, MBBS 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 Neurology. 3. Board certified in Neurology. 4. Completion of fellowship in Neuroradiology, or 5. Training in Neuroradiology or Diagnostic Neuroimaging. 	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> 1. Documentation of number of procedures performed during the past 12 months, or 2. Please indicate the name and address of Two (2) Neurologists trained in the procedure(s) whom we may contact to attest to your competency to perform the procedures requested. <p>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</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 procedures performed during the past 24 months, or 2. 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>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