

Regions Hospital

Delineation of Privileges

Pediatrics

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 - Privileges to Provide Care in General Pediatrics

| Privileges | Basic Education & Minimal Formal Training | Required Documents and Experience |
|--|---|---|
| Privileges include the treatment of patients between the ages of birth to 18 years (with certain age exceptions), the performance of procedures that do not carry a significant threat to life including admission, consultant, and the treatment of major or complicated illnesses. | <ol style="list-style-type: none"> 1. MD or DO, MBBS 2. Successfully completed a three year pediatric or internal medicine/pediatric residency program approved by the ACGME, AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec 3. Board certification or progressing toward certification. | <p><u>New Applicants:</u></p> <ol style="list-style-type: none"> 1. Letter of reference from two (2) physician peers who can attest to your competency or training. Please indicate names and addresses of the peers whom we may contact. <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. Must provide documentation of direct or supervisory experience in the care of at least 24 general pediatric patients in 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: _____ Phone/Fax # _____</p> |

CORE II - Privileges to Provide Care to Newborns

| Privileges | Basic education | Required previous experience |
|--|--------------------------|--|
| <p>Privileges include the ability to provide care to all newborns, including those with potentially life-threatening illnesses. Consultation is suggested in the complex, life threatening situations.</p> | <p>1. Same as Core I</p> | <p><u>New Applicants:</u></p> <ol style="list-style-type: none"> Documentation of the provision of care to at least 24 newborns during the past 24 months or Letter of reference from a physician peer who can attest to your competency or training. Please indicate name and address of the peer whom we may contact. <p>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax#: _____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> Documentation of the provision of care to at least 24 newborns during the past 24 months, or 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> |

CORE III - Special Privileges in Pediatrics

| Basic Education & Minimal Formal Training: | Required previous experience: |
|--|--|
| <ol style="list-style-type: none"> MD or DO, MBBS Successful completion of a three-year pediatric or internal medicine/pediatric residency program approved by the ACGME, AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec Board certified or progressing toward certification. | <p><u>New Applicants:</u></p> <ol style="list-style-type: none"> Documentation of extensive post residency or subspecialty training or experience in the treatment of the requested privileges beyond board certification is required. <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> Documentation of the number of special procedures performed in past 24 months, or Evaluation of your competency in the privilege area requested 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 requests for pediatric surgical procedures: | |
|---|--|
| <input type="checkbox"/> neonatal circumcision | <input type="checkbox"/> simple fracture and dislocation |
| Special requests for pediatric diagnostic procedures: | |
| <input type="checkbox"/> proctoscopy | <input type="checkbox"/> laryngoscope |
| <input type="checkbox"/> subdural tap | <input type="checkbox"/> abdominal paracentesis |
| <input type="checkbox"/> thoracentesis | <input type="checkbox"/> bladder tap |
| <input type="checkbox"/> skin biopsy | |
| Special requests for pediatric sub-specialty procedures: | |
| <input type="checkbox"/> renal biopsy | <input type="checkbox"/> peritoneal dialysis |
| <input type="checkbox"/> hemodialysis | <input type="checkbox"/> pericardiocentesis |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> lung biopsy |
| <input type="checkbox"/> bone marrow biopsy | <input type="checkbox"/> bronchography |
| <input type="checkbox"/> ventricular tap | <input type="checkbox"/> gastroscopy |
| <input type="checkbox"/> angiography, lymphangiography | <input type="checkbox"/> chest tube insertion (non-emergency) |
| <input type="checkbox"/> endoscopy | <input type="checkbox"/> bronchoscopy |
| <input type="checkbox"/> hepatic biopsy | <input type="checkbox"/> ventilatory care of neonates |
| <input type="checkbox"/> tracheostomy | <input type="checkbox"/> sigmoidoscopy |
| <input type="checkbox"/> myelography | <input type="checkbox"/> intracranial pressure monitor placement |
| <input type="checkbox"/> cisternal puncture | |

TO BE COMPLETED BY APPLICANT:

I agree to supply Regions Hospital Credentialing Office with all of the information that has been requested of me for the privileges that I have applied for in the previous pages. I also understand that my application for privileges will not proceed until the information is received.

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