

***Regions Hospital  
Delineation of Privileges  
Internal Medicine – Pulmonary /Critical Care Medicine***

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 Non-Staff Privileges Internal Medicine (designated for Moonlighters)**

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
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 above the age of 17 admitted or in need of care to treat general medical problems. These privileges do not include the special requests located on the following pages.	<ol style="list-style-type: none"> <li>1. MD, DO, MBBS</li> <li>2. 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.</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Please indicate names and addresses of two (2) physicians whom we may contact who are not peers, who can comment on your current clinical competence.</li> </ol> Name: _____ Name of Facility: _____ Address: _____ Ph/Fax: _____  Name: _____ Name of Facility: _____ Address: _____ Ph/Fax: _____  <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Must supply documentation of number of inpatient services performed during the past 24 months, <b>or</b></li> <li>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.</li> </ol> Name: _____ Name of Facility: _____ Address: _____ Ph/Fax: _____

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

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include admission, work-up, diagnosis and provision of non-surgical treatment including consultation for patients above the age of 17 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>	<ol style="list-style-type: none"> <li>1. MD, DO, MBBS</li> <li>2. Successful completed of an ACGME or AOA approved residency training program in Internal Medicine/Pulmonary Medicine/Critical Care.</li> <li>3. Board certification or progressing toward board certification in Internal Medicine.</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Documentation of inpatient service to at least 30 patients in the past 12 months, <b>or</b></li> <li>2. Please indicate names and addresses of two (2) physicians whom we may contact who are not peers, who can comment on your current clinical competence.</li> </ol> <p>Name: _____            Name of Facility: _____            Address: _____            Ph/Fax: _____</p> <p>Name: _____            Name of Facility: _____            Address: _____            Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Must supply documentation of number of inpatient services performed during the past 24 months, <b>or</b></li> <li>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.</li> </ol> <p>Name: _____            Name of Facility: _____            Address: _____            Ph/Fax: _____</p>

**CORE III- Special Privileges Internal Medicine**

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p><input type="checkbox"/> Flexible Sigmoidoscopy</p> <p><input type="checkbox"/> Central Line Placement</p>	<ol style="list-style-type: none"> <li>1. MD, DO, MBBS</li> <li>2. Successful completed of an ACGME or AOA approved residency training program in Internal Medicine</li> <li>3. Board Certification or progressing toward board certification in Internal Medicine.</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Documentation of number of procedures performed within the past 12 months, <b>or</b></li> <li>2. Please indicate name and address of a physician trained in the privilege area whom we may contact that can comment on your current competency to perform the procedure(s) requested.</li> </ol> <p>Name: _____            Name of Facility: _____            Address: _____            Ph/Fax: _____</p> <p>Name: _____            Name of Facility: _____            Address: _____            Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u>            Same criteria as outlined in Core II.</p>

**CORE IV- Pulmonary and Critical Care Privileges**

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>General privileges in Pulmonary and Critical Care are that which are outlined in Core II in addition to the ability to provide consultation services on issues involving Pulmonary and Critical Care.</p>	<ol style="list-style-type: none"> <li>1. MD, DO, MBBS</li> <li>2. 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.</li> <li>4. Successful completed of an ACGME or AOA approved residency training program in Internal Medicine/Pulmonary &amp; CC</li> <li>3. Board Certification or progressing toward board certification in Pulmonary Medicine.</li> <li>4. Completion of an accredited fellowship in Pulmonary &amp; CC medicine</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Documentation of completion of a Pulmonary and Critical Care fellowship, <b>or</b></li> <li>2. Demonstrated competency by proctorship by a Pulmonary and Critical Care physician with privileges at Regions Hospital or designee. Please indicate name and address of the physician whom we may contact.</li> </ol> <p>Name: _____            Name of Facility: _____            Address: _____            Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u>            Same criteria as outlined in Core II.</p>

**CORE V- Special Privileges Pulmonary and Critical Care**

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
<input type="checkbox"/> Routine Management of Mechanical Ventilator <input type="checkbox"/> Swan-Ganz <input type="checkbox"/> Fiberoptic Bronchoscopy <input type="checkbox"/> Chest Tube Placement <input type="checkbox"/> Arterial Line Placement  <input type="checkbox"/> Pleural Biopsy <input type="checkbox"/> Endotracheal Intubation  <input type="checkbox"/> <b>**Oscillator Management – available to critical care physicians only.</b>	1. Same as Core IV	<u>New Applicants:</u> 1. Documentation of completion of fellowship in Pulmonary/Critical Care, <b>or</b> 2. Documentation of a formal training program in the procedure(s) listed, <b>or</b> 3. Name and address of a Pulmonary/Critical Care physician whom we may contact who has witnessed you performing the procedure(s), <b>or</b> 4. Demonstrated competency by proctorship by a Pulmonary/Critical Care physician with privileges at Regions Hospital or designee. Please indicate name and address of the physician whom we may contact. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____  5. <b>** Oscillator Management - available to critical care physicians only.</b> a) Satisfactory completion of self study including passing of post test b) Satisfactory completion of checklist competency (controls and readouts).  <u>Reappointment Applicants:</u> Same criteria as outlined in Core II

**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

# *Regions Hospital Delineation of Privileges Conscious Sedation*

**Applicant's Name:** \_\_\_\_\_  
Last
First
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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>	<p>3. MD, DO, MBBS, DPM, DMD, DDS,            4. 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.</p>	<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><u>Reappointment Application:</u></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>

**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

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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

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Date