Texas Health Presbyterian Hospital ROCKWALL
Healing Hands. Caring Hearts.

Clinical Privileges in **Hematology and Oncology**

DEPARTMENT: *MEDICINE* ***SECTION:*** *HEMATOLOGY AND ONCOLOGY*

Name: _____
(please print)

Qualifications: EDUCATION / TRAINING / EXPERIENCE

Core privileges in Hematology and Oncology require a MD or DO and current certification in Internal Medicine; current certification in Hematology by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine OR Successful completion of an accredited residency training in Hematology that qualifies for Board Certification. Board certification maybe required within five years of appointment to medical staff based on departmental guidelines.

PRIVILEGING

*As documented by my experience and training on the Application for Appointment/Reappointment to the Medical Staff, I request privileges as indicated below. Applicant: Place a **check mark and initial** in the **(R) column** for each privilege requested. Initial applicants must provide documentation of the number and types of hospital cases during the past 24 months.*

(R)=Requested (A)=Recommended as Requested (C)= Recommended with Conditions (N)=Not Recommended

Note: If recommendations for clinical privileges includes a condition, modification or not recommended, the specific condition and reason for same must be stated on the last page of this form.

(for office use only) **Initial** _____ **Renewal**_____ Effective ___/___/___ to ___ /___/ ____

(R)	*(A)*	*(C)*	*(N)*	***CATEGORY I: HEMATOLOGY CORE PRIVILEGES***	***Department Chair Initials***
				Privileges to admit, consult, evaluate, diagnose, and provide non-surgical treatment to patients—except as specifically excluded from practice and except for those advanced procedure privileges listed below—with illnesses and disorders of the blood, blood-forming tissues, and immunologic system. Privileges include, but are not limited to, bone marrow aspirations and biopsy, administration of chemotherapy, the management and care of indwelling venous access catheters, plasmapheresis, lymph node aspiration, therapeutic phlebotomy, therapeutic thoracentesis and paracentesis, and cellular pheresis.	
				Newborn & infants to 2 years	
				Children 2 years to 14 years	
				Adolescents 14 to 18 years	
				Adults 18 years and greater	
(R)	*(A)*	*(C)*	*(N)*	***CATEGORY I: ONCOLOGY CORE PRIVILEGES***	***Department Chair Initials***
				Privileges to admit, consult, evaluate, diagnose, and provide non-surgical treatment for patients—except as specifically excluded from practice and except for those advanced procedure privileges listed below—with cancer. Privileges include, but are not limited to, bone marrow biopsy and interpretation, administration of chemotherapeutic agents and biological response modifiers through all therapeutic routes, management and maintenance of indwelling venous access catheters, and therapeutic thoracentesis and paracentesis, and cellular pheresis..	
				Newborn & infants to 2 years	
				Children 2 years to 14 years	
				Adolescents 14 to 18 years	
				Adults 18 years and greater	

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(R)	(A)	(C)	(N)	***CATEGORY II: HEMATOLOGY AND ONCOLOGY SPECIAL PRIVILEGES*** ***Must meet the requirements outlined for Category I AND demonstrate proof of additional training, clinical competence and/or experience, with documentation of such additional qualifications.***			***Department Chair Initials***
				Privilege Requested	***Required Previous Experience***	***Reappointment Criteria***	
				Administration of Moderate Sedation	*For initial clinical privilege request, physicians must read the Moderate Sedation Self Directed Learning Activity, take and pass a post test with a passing score of 80% or better and documentation current ACLS certification or document successful demonstration of airway management, oral airway insertion and ambu bag usage.*		

PRIVILEGE CRITERION

Provisional Privileges: *Provisional privileges, during the first 6 months of practice of the procedure at Presbyterian Hospital of Rockwall, are conferred to facilitate the pursuit of full anesthesiology privileges at Presbyterian Hospital of Rockwall. With this classification, it is appropriate for the physician to assist in cases and complete any proctoring requirements to meet full privilege requirements for Presbyterian Hospital of Rockwall.*

Special procedures: *Unless otherwise set out in this document, successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship or other acceptable experience; and documentation of competence to obtain and retain clinical privileges as set forth in medical staff policies governing the exercise of specific privileges.*

Use of Laser: *Completion of an approved 6 hour minimum CME course which includes training in laser principles of safety, basic laser physics, laser tissue interaction, discussions of the clinical specialty field and hands-on experience with lasers. A letter outlining the content and successful completion of course must be submitted, or documentation of successful completion of an approved residency in a specialty or subspecialty which included training in laser principles and safety, basic laser physics, laser tissue interaction, discussions of the clinical specialty fields and a minimum of 4 hours didactic and 2 hours hands-on experience with lasers.*

Moderate Sedation: *For initial clinical privilege request, physicians must read the Moderate Sedation Self Directed Learning Activity, take and pass a post test with a passing score of 80% or better and documentation current ACLS certification or document successful demonstration of airway management, oral airway insertion and ambu bag usage.*

Observation / Proctoring Requirements: *Guidelines, scheduling, payment and approval process for the proctoring programs are defined in the Medical Staff policy.*

Reappointment Requirements: *Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Practice will be monitored for the first 12 months as per JCAHO guidelines.*

Continuing Medical Education: *In compliance with JCAHO standard, the physician must participate in continuing medical education (CME) as per state licensure regulations, outlined by the medical staff by-laws rules and regulations.*

Participation in Societies: *Active participation in societies related to this field is also strongly recommended.*

Note: If any privileges are covered by an exclusive contractual agreement, physicians who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training and experience.

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ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Presbyterian Hospital of Rockwall, and

1) I understand that:
   a) In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation and agree to be proctored.
   b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.
2) I do attest that I have participated in continuing medical education activities related to the privileges I have requested.

_____ _____ _____/_____/_____
Applicant Name – Printed Signature Date

DEPARTMENT CHAIRMAN RECOMMENDATION

I have reviewed the requested clinical privileges, as well as the appointment / reappointment application, performance improvement profile, and other pertinent appointment / reappointment information. Based on my review I propose the following:

☐ **Recommend**	☐ **Recommend with Conditions**	☐ **Not Recommended**	☐ **Deferred for Committee Discussion**
Comments:			

_____ _____/_____/_____
Department Chairman Signature **Date**

ACCEPTANCE AND APPROVAL

_____ _____/_____/_____
Credentials Chairman Signature **Date**

_____ _____/_____/_____
President of Medical Staff Signature **Date**