LAC+USC MEDICAL CENTER ATTENDING STAFF ASSOCIATION
DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF
INPATIENT ANTICOAGULATION
PHARMACIST

NAME OF APPLICANT ____ **DATE**______________________

☐ Initial Appointment and/or Additional Privileges ☐ Reappointment

Applicant: Check off only those privileges expected to be performed at the site where you will be working. Note that privileges granted may only be exercised at the site(s) and setting(s) recommended by the Department Chair/Chief/Designee. Shaded areas indicate that the privilege is not applicable for that particular entity.

Department Chair/Chief/Designee: Initial the Recommended column for approved privileges. If applicable, check off the "Not Recommended" boxes. Documentation of all privileges must be provided for all privileges on the last page of this form.

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LACUSC Medical Center			Competency	Other
	Follow department guidelines and standardized procedures, policies and protocols found in the Interdisciplinary Practice Committee (IDPC) Policy and Procedures Manual. **Core Privileges**: Basic privileges in Pharmacy include: - Institute treatment essential for the life of the patient (ie.,BCLS, ACLS), - Obtain a history, - Perforn a physical examination, - Order laboratory and diagnostic procedures, - Interpret laboratory data, - Interpret diagnostic studies, - Determine assessment and interval for follow up, - Conduct patient and family education, - Manage and provide consultations, - Document care rendered in medical record For the following ages:			
	Neonates and Infants from 0 to 2 years of age			
	Children from 3 to 13 years of age			
	Adolescents and Young Adults 14 years of age and older			
	Furnishing of written orders for medications and medical devices.			
	SPECIFIC PRIVILEGES			
	1. Manage intravenous (IV) anticoagulation therapy. (e.g., heparin and argatroban)			

REQUESTED LAC+USC Medical Center	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED Competency	NOT RECOMMENDED Other
	2. Monitor patient receiving continuous IV anticoagulant infusions.			
	3. Manage conversion from continuous IV anticoagulant to oral anticoagulants (e.g., warfarin).			
	4. Manage conversion from continuous IV anticoagulation to subcutaneous anticoagulants.			
	5. Manage oral anticoagulant (e.g., Warfarin, Rivaroxaban) and low molecular weight heparin (e.g., Enoxaparin).			
	6. Manage conversion from oral anticoagulant to IV or subcutaneous anticoagulant (bridging therapy).			

ACKNOWLEDGMENT OF PRACTITIONER:

I hereby certify that I have no physical or mental impairment which would interfere with my practice and I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise in each group of procedures requested. I understand that in making this request I am bound by the LAC+USC Bylaws and/or policies of the hospital and attending staff. Privileges as granted will be practiced in accordance with department procedures.

____ ____________________

Applicant's Signature Date

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

________________________________ ______________________________ ____________

Supervising Physician (print) (Signature) Date

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other

Department Chair/Chief/Designee recommendation:

If there are any recommendations of privileges that need to be modified or have conditions added, indicate here:

Privilege#:____

Condition/Modification/Explanation:____

____

If privileges are NOT recommended based on COMPETENCY, provide explanation:

Privilege#:____

Explanation for NOT recommending based on
COMPETENCY:____

____

If supplemental documentation provided, check here: ☐

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

____ ______________________________

SIGNATURE OF THE DEPARTMENT CHAIR/CHIEF/DESIGNEE *DATE*

APPROVED BY INTERDISCIPLINARY PRACTICE COMMITTEE ON:	APPROVED BY EXECUTIVE COMMITTEE ON:
APPROVED BY GOVERNING BODY ON:	PERIOD ENDING:

Name: ____