

**LAC+USC MEDICAL CENTER ATTENDING STAFF ASSOCIATION
 DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF PEDIATRICS
 NURSE PRACTITIONERS**

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 LAC+USC Medical Center	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
			Competency	Other
	Follow department guidelines and standardized procedures, policies and protocols found In the Advance Practice Policy and Procedures Manual. Core Privileges: Basic privileges in Pediatrics include: - Institute treatment essential for the life of the patient (i.e. BCLS,) - Transfer patients to observation areas and between hospital units, - Assessment, diagnosis & management of acute and chronic conditions, provide primary healthcare, - Obtain a history, - Perform a physical examination, - Order laboratory and diagnostic procedures, - Interpret laboratory data, - Interpret diagnostic studies, - Obtain informed consent for procedures, - Perform and/or assist in the performance of diagnostic studies within the scope of specialty services, - Perform and/or assist in the performance of therapeutic procedures within the scope of specialty services, - Monitor patients throughout procedure and during recovery period, - Determine assessment and interval for follow up, - Determine hospital discharge and appropriate follow-up, - Conduct patient and family education, - Manage and provide consultations, - Document patient interactions, - Document care rendered in medical record, and - Complete discharge summaries of patients.			
	for the following ages:			
	Neonates and Infants from 0 to 2 years of age			

Name: _____

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			Competency	Other

	Children from 3 to 13 years of age			
	Adolescents and Adults, 14 years of age and older			
	Furnishing of written orders for medications and medical devices.			
	AREA OF SPECIALIZATION - PEDIATRICS			
	1. Allergy & Immunology			
	2. Endocrinology			
	3. General			
	4. Hematology/Oncology			
	5. Maternal-Child & Adolescent			
	6. Neonatal			
	7. Neurology			
	8. Pulmonary/Critical Care			
	SPECIFIC PRIVILEGES - PEDIATRICS			
	1. Incision and drainage of subcutaneous abscess			
	2. Venipuncture/phlebotomy & arterial puncture			
	3. Neonatal resuscitation			

Name: _____

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	4. Lumbar puncture			
	5. Toenail removal under local anesthesia			
	6. Percutaneous IV catheter placement/removal for procedures			
	7. Subcutaneous/intradermal/intramuscular/IV injections			
	8. Simple suturing and removal of sutures			
	9. Frenotomy			
	10. Peripheral IV placement			
	11. Nasogastric/orogastric tube placement			
	12. Bladder catheterization			
	<u>RESTRICTED TO ALLERGY & IMMUNOLOGY</u>			
	1. Perform skin testing			
	2. Perform pulmonary function testing and related bronchodilator challenges.			
	3. Furnish orders and administers injections (including but not limited to immunotherapy, omalizumab, and epinephrine).			
	4. Orders and administers medications needed for treatment of asthma and/or allergic reactions.			
	<u>RESTRICTED TO HEMATOLOGY/ONCOLOGY</u>			
	1. Intravenous administration of chemotherapy agents per orders			

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	2. Intrathecal administration of chemotherapy agents per orders			
	<u>RESTRICTED TO NEONATAL</u>			
	1. Endotracheal intubation/extubation and tracheal aspiration			
	2. Catheterization and removal of umbilical vessel catheter			
	3. Thoracentesis			
	4. Chest Tube Placement			
	5. Blood Exchange Transfusion			
	6. Percutaneous Central Line placement			
	7. Suprapubic bladder aspiration			
	8. Peripheral arterial and venous line placement			
	9. Ordering of Parenteral Nutrition			
	10. Neonatal resuscitation			
	<u>RESTRICTED TO MATERNAL-CHILD & ADOLESCENT</u>			
	1. Management of primary health care from birth through adulthood of HIV infected, at risk, exposed and uninfected children, including physical examination, ordering laboratory and radiologic tests, and immunizations.			
	2. Management of primary health, and HIV care of HIV positive and HIV at risk pregnant women			

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			Competency	Other
	3. Management of HIV disease and complications in pediatrics, adolescent, and adult patients including physical examination, ordering laboratory and radiologic tests and immunizations.			
	4. Basic gynecologic evaluation of adolescent and adult women including bimanual examination, speculum examination and Papanicolaou smear			
	5. HIV testing and counseling			
	RESTRICTED TO NEUROLOGY			
	1. Programming of vagal nerve stimulator			
	PRIVILEGES REQUIRING ADDITIONAL TRAINING			
	1. Placement / removal of implantable contraceptives, such as Nexplanon			
	VIOLENCE INTERVENTIONAL PROGRAM (VIP)			
	<u>AREA OF SPECIALIZATION</u>			
	1. Violence Interventional Program/Adults			
	Violence Interventional Program/Community-Based and Treatment Center (CATC)			
	<u>SPECIFIC PRIVILEGE</u>			
	1. Colposcopy			

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

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: