

**LAC+USC MEDICAL CENTER ATTENDING STAFF ASSOCIATION
 DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF
 PHARMACY - ADVANCED PRACTICE CLINICAL PHARMACY
 SERVICES PHARMACIST – HEPATITIS C CLINIC**

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	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
			Competency	Other
	Follow Collaborative Practice Agreements, department guidelines and standardized Medical Center procedures, policies and protocols Core Privileges: Basic privileges of Clinical Pharmacist functions include: - Obtain a history - Perform an evaluation that may include drug therapy-related patient assessment procedures including physical examination and vital sign measurement - Order laboratory and diagnostic procedures per protocol or in consultation with other healthcare providers - Prescribing (May initiate, discontinue, and adjust dose of medications per protocol) - Interpret laboratory data, - Interpret diagnostic studies - Determine assessment and interval for follow up - Conduct patient and family education - Manage and provide consultations - Communication with health care team - 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			
	SPECIFIC PRIVILEGES			

Name: _____

REQUESTED LAC+USC	DESCRIPTION OF PRIVILEGE	RECOMMENDE	NOT RECOMMENDED	
			Competency	Other
	1. Institute and manage Hepatitis C therapy as per protocol.			

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

Name: _____

REQUESTED LAC+USC	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
			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: _____