LAC+USC MEDICAL CENTER ATTENDING STAFF ASSOCIATION
DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF FAMILY MEDICINE

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.

Department Chair/Chief/Designee: Initial the Recommended column for approved privileges. If applicable, check off the "Not Recommended" boxes. Certain privileges require documentation of training and/or competency. This documentation must be attached to this form when submitted. Please see appendix for additional details.

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other
	GENERAL			
	Ambulatory setting: Perform H&Ps, provide consultation, order diagnostic studies and treatment of diseases for the following ages:			
	Adolescents and Young Adults 14 years of age and older			
	Local anesthesia			
	CATEGORY A CORE PRIVILEGES			

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other
	Core privileges are those privileges and responsibilities of admitting, diagnosing, and treating patients without major complication as well as diagnostic procedures customarily employed in the general medical care of the patients. A major complication is defined as a situation where the patient's condition has reached a level of complexity that requires consultation of referral to a sub specialty. These complexities may require technical as well as cognitive skills beyond the level of training of the family physician. For the following ages:			
	Arthrocentesis			
	Minor dermatologic surgical procedures			
	Suture of minor lacerations			

PRIVILEGES NOT INCLUDED ON THIS FORM: A request to perform any procedure or treatment not included on this form must be submitted to the Attending Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.

TEMPORARY CLINICAL PRIVILEGES: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted as per the LAC+USC Attending Staff Association Bylaws.

Name: ____

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 medical staff.

______________________________ ______________________________

APPLICANT'S SIGNATURE DATE

Name: ______________________________________

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

Department Chair/Chief/Designee:

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 CREDENTIALS & PRIVILEGES COMMITTEE ON:	APPROVED BY EXECUTIVE COMMITTEE ON:
APPROVED BY GOVERNING BODY ON:	PERIOD ENDING:

Name: ____