DELINEATION OF AMBULATORY CLINICAL PRIVILEGES FOR THE DEPARTMENT OF ADULT MEDICINE SERVICES/DERMATOLOGY

LAC+USC _____
HUDSON CHC _____
ROYBAL CHC _____
EL MONTE CHC _____

LAC+USC HEALTHCARE NETWORK

NAME OF APPLICANT _____ **SIGNATURE** _____

DATE

APPLIED	DESCRIPTION OF PRIVILEGE	PROVISIONAL	APPROVED	DENIED C | O
	All physicians granted privileges in the Healthcare Network/Adult Medicine are granted clinical privileges to perform the basic diagnostic & therapeutic procedures listed below for General Internal Medicine. These procedures are granted unless indicated otherwise.			
	AREA OF SPECIALIZATION			
☐	1. **Adult Medicine from ages 14 years and older**			
_____	• Arterial puncture	_____	_____	_____
_____	• Debridement of wound	_____	_____	_____
_____	• Excisional biopsy of small skin lesions	_____	_____	_____
_____	• Foreign body removal, subcutaneous tissue	_____	_____	_____
_____	• Incision & drainage of subcutaneous abscesses	_____	_____	_____
_____	• Intravenous puncture	_____	_____	_____
_____	• Local anesthesia	_____	_____	_____
_____	• Lumbar puncture	_____	_____	_____
_____	• Placement of peripheral intravenous cannulas	_____	_____	_____
_____	• Suture of minor lacerations	_____	_____	_____

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	AREAS OF SPECIALIZATION (List from Allergy to Rheumatology)				
_____	• Allergy	_____	_____	_____	
_____	• Cardiology	_____	_____	_____	
_____	• Dermatology	_____	_____	_____	
_____	• Endocrinology	_____	_____	_____	
_____	• Gastroenterology	_____	_____	_____	
_____	• Hematology	_____	_____	_____	
_____	• Hepatology	_____	_____	_____	
_____	• Immunology	_____	_____	_____	
_____	• Infectious Disease	_____	_____	_____	
_____	• Internal Medicine, General	_____	_____	_____	
_____	• Nephrology	_____	_____	_____	
_____	• Oncology	_____	_____	_____	
_____	• Pulmonary Disease	_____	_____	_____	
_____	• Renal Disease	_____	_____	_____	
_____	• Rheumatology	_____	_____	_____	

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	SPECIFIC PRIVILEGES			
☐	**1. ALLERGY**	_____	_____	_____
☐	**2. CARDIOLOGY**			
_____	• 2-D echocardiography	_____	_____	_____
_____	• M-mode echocardiography	_____	_____	_____
_____	• Exercise stress testing	_____	_____	_____
_____	• Stress echocardiography	_____	_____	_____
☐	**3. GASTROENTEROLOGY/HEPATOLOGY**			
☐	**4. ENDOCRINOLOGY**			
☐	**5. HEMATOLOGY**			
_____	• Phlebotomy, therapeutic	_____	_____	_____
☐	**6. INFECTIOUS DISEASE**			
_____	• Arthrocentesis	_____	_____	_____

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_____	• Lumbar Puncture	_____	_____	_____	
_____	• Paracentesis	_____	_____	_____	
☐	**7. NEPHROLOGY**				
☐	**8. ONCOLOGY**				
☐	**9. PULMONARY DISEASE**				
☐	**10. RENAL DISEASE**				
☐	**11. RHEUMATOLOGY**				
_____	• Arthrocentesis	_____	_____	_____	
_____	• Synovial biopsy	_____	_____	_____	
_____	• Intra-articular injection	_____	_____	_____	
_____	• Trigger point injection	_____	_____	_____	
☐	**12. OTHER**	_____	_____	_____	
_____	• Lumbar puncture	_____	_____	_____	
_____	• Pleural aspiration				

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DERMATOLOGY

In helping to evaluate your qualifications, please complete the following information if you are requesting clinical privileges in Dermatology.

(*****) Please provide documentation.

_____(*****) Certified as a Diplomate of the American Board of Dermatology

Date: _____

_____ (*) Board Eligible (ABD)

_____ Other board Certificate: _____ Date:)_____

CATEGORY I

☐	1. ROUTINE DERMATOLOGY PRIVILEGES			
_____	Administration and interpretation of patch testing and intradermal tests.	_____	_____	_____
_____	Clinical mycological techniques including potassium hydroxide preparation, culture and identification of dermatophytes, molds and contaminants, bacterial gram stains and Tzanck Smears	_____	_____	_____
_____	Review of dermatologic pathology slides as interpreted by the Department of Pathology in order to correlate with the clinical disease state.	_____	_____	_____
_____	Diagnosis and treatment of simple and more complex life threatening or disfiguring dermatologic disorders.	_____	_____	_____
_____	Routine surgical procedures, except those specified in Category II	_____	_____	_____

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☐	**REQUIREMENTS**			
_____	1. An unrestricted license to practice medicine in the State of California.	_____	_____	_____
_____	2. Membership on the Attending Staff of LAC+USC Medical Center, or temporary privileges granted by the Chief of Staff of the hospital.	_____	_____	_____
_____	3. Either of the following:	_____	_____	_____
_____	4. a. Certification as a Diplomate of the American Board of Dermatology.	_____	_____	_____
_____	b. Three years of training in an approved Dermatology residency program (including credit for other specialty training acceptable to the board).	_____	_____	_____
	CATEGORY II			
☐	1. Special Dermatology Privileges Category II Privileges are Privileges in areas of special competence requiring experience and/or training beyond that common to all dermatologists.	_____	_____	_____
☐	2. Mohs Surgery	_____	_____	_____
☐	3 Advance Surgical Techniques: (Check specific privileges desired)			
_____	a. Nail Surgery	_____	_____	_____
_____	b. Skin grafts	_____	_____	_____
_____	c. Local flaps	_____	_____	_____

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_____	d. Sclerotherapy	_____	_____	_____
_____	e. Wedge excision of lip or ear	_____	_____	_____
_____	f. Scar revision	_____	_____	_____
_____	g. Injectable tissue augmentation	_____	_____	_____
	h. Laser Surgery			
_____	1. CO2 Laser	_____	_____	_____
_____	2. Q-Switched Nd: YAG Laser	_____	_____	_____
_____	i. Liposuction	_____	_____	_____
_____	j. Hair replacement surgery	_____	_____	_____
_____	k. Dermabrasion	_____	_____	_____
_____	l. Chemical peel	_____	_____	_____
	REQUIREMENTS			
_____	1. Must meet the qualifications of Category I.	_____	_____	_____

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_____	2. Satisfactory completion of a fellowship, course or equivalent training program acceptable to the Chief of the Division of Dermatology; or submission of sufficient case material as proof of experience for review and approval by the Chief of the Division of Dermatology. Appropriate training received in _____ residency; _____preciptorship; _____courses.	_____	_____	_____	

PROVISIONAL PRIVILEGES	*FINAL APPROVAL*
DIVISION APPROVAL DATE	DIVISION APPROVAL DATE
DEPARTMENT CHAIRMAN APPROVAL DATE	DEPARTMENT CHAIRMAN APPROVAL DATE
CREDENTIALS COMMITTEE APPROVAL DATE	CREDENTIALS COMMITTEE APPROVAL DATE
APPROVED BY CREDENTIALS ADVISORY COMMITTEE ON:	EXECUTIVE COMMITTEE ON:
GOVERNING BODY ON:	PERIOD ENDING:

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