LAC+USC MEDICAL CENTER & HEALTHCARE NETWORK ATTENDING STAFF ASSOCIATION
DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF PEDIATRICS

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	
M	E	H	R			Competency	Other
				1. **Core Privileges in Pediatrics:** includes performing a history and physical, interpreting laboratory studies, interpreting and performing diagnostic studies and treatment plans 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			
				ACUTE CARE PEDIATRICS			
				2. Arterial line placement			
				3. Arthrocentesis			
				4. Central line placement			
				5. Chest tube placement			

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REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				6. Endotracheal intubation			
				7. I&D abscess			
				8. Interosseous line placement			
				9. Lumbar puncture			
				10. Moderate Sedation – Must have fulfilled the required elements and successfully passed the competency examination.			
				11. Parencentesis			
				12. Suprapubic bladder aspiration			
				13. Suture laceration			
				14. Thoracentesis			
				15. Umbilical vein & artery catherization			
				16. Venous cut down			
				INTENSIVE CARE PEDIATRICS (Restricted to physicians in PICU and NICU)			
				17. Exchange transfusion			
				18. High frequency ventilation			

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				19. Swan-Ganz catheter placement			
				RESTRICTED TO ALLERGIST			
				20. Rhinoscopy			
				RESTRICTED TO CARDIOLOGIST			
				21. Cardiac pacemaker placement			
				22. Cardiac catheterization			
				RESTRICTED TO GASTROENTEROLOGIST			
				23. Percutaneous liver biopsy			
				24. Endoscopy			
				RESTRICTED TO HEMATOLOGIST/ONCOLOGIST			
				25. Bone marrow and bone marrow biopsy			
				RESTRICTED TO NEPHROLOGIST			
				26. Percutaneous renal biopsy			
				27. Peritoneal dialysis			
				28. Hemodialysis			

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				PRIVILEGES REQUIRING ADDITIONAL TRAINING			
				29. Placement / removal of implantable contraceptives, such as Nexplanon			
				30. Placement / removal of IUDs			

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.

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

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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:

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