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

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	
LAC+USC Medical Center			Competency	Other
	Physician Assistant's (PA) , in accordance with the Delegation of Services Agreement between the PA and the Supervising Physician, may provide any legal medical service that is within the PA's scope of medical practice. **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			

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other
	Children from 3 to 13 years of age			
	Adolescents and Adults, 14 years of age and older			
	Transmital 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. Pulmonary/Critical Care			
	SPECIFIC PRIVILEGES - PEDIATRICS			
	1. Incision and drainage of subcutaneous abscess			
	2. Venipuncture/phlebotomy & arterial puncture			
	3. Neonatal resuscitation			
	4. Lumbar puncture			

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other
	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			
	RESTRICTED TO ALLERGY & IMMUNOLOGY			
	1. Perform skin testing			
	2. Perform pulmonary function testing and related bronchodilator challenges.			
	3. Transmits orders and administers injections (including but not limited to immunotherapy, omalizumab, and epinephrine).			
	4. administers medications needed for treatment of asthma and/or allergic reactions as per orders			
	RESTRICTED TO HEMATOLOGY/ONCOLOGY			
	1. Intravenous administration of chemotherapy agents per orders			
	2. Intrathecal administration of chemotherapy agents per orders			

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other
	RESTRICTED TO NEONATAL			
	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. Lumbar Puncture			
	8. Suprapubic bladder aspiration			
	9. Peripheral arterial and venous line placement			
	10. Ordering of Parenteral Nutrition			
	11. Neonatal resuscitation			
	RESTRICTED TO MATERNAL-CHILD & ADOLESCENT			
	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			

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

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: