**LAC+USC MEDICAL CENTER ATTENDING STAFF ASSOCIATION**
**DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF MEDICAL EDUCATION**

**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 |
| | | | | **TEACHING PRIVILEGES AND SUPERVISE ICM EDUCATION PROGRAMS** | | | |
| | | | | I. This category involves privileges for instructors in supervised student education programs in activities that do not include direct patient care or resident supervision. In this category, patients may be seen and charts reviewed in the context of student teaching. | | | |

**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

**Name of Applicant:** _____

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 of Applicant:** _____