ATRIUM HEALTH
REAPPOINTMENT DOP
ALLERGY AND IMMUNOLOGY
SPECIALTIES OF INTERNAL MEDICINE AND PEDIATRICS

PRINT YOUR NAME:_____

	YES		NO*	I have participated in direct patient care in the hospital setting and/or outpatient practice setting within the past two (2) years.

***If the answer is No, please do not complete this form. Contact the Medical Staff Office at (704) 355-2147 for additional instructions regarding the required proctoring process.**

To be eligible for core privileges in Allergy and Immunology, the applicant must meet the following qualifications:

☐ If the applicant is not currently subspecialty certified in Allergy and Immunology by the American Board of Allergy and Immunology (ABAI) or the American Osteopathic Association in Allergy and Immunology, the applicant must:

1. Provide documentation of successful completion of an ACGME or AOA accredited Allergy and Immunology fellowship training program, within the past five (5) years; **AND**

2. Verification from the fellowship program director that the Applicant successfully completed the program. Experience must include evidence of current clinical competence during the past two (2) years. The Applicant has the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

☐ If the applicant is currently subspecialty certified in Allergy and Immunology by the American Board of Allergy and Immunology (ABAI) or the American Osteopathic Association with Certification of Special Qualifications in Allergy and Immunology, the applicant must:

1. Documentation of inpatient or consultative services for at least six (6) patients during the past two (2) years; **OR**

1. Provide documentation of subspecialty certification in Allergy and Immunology from the American Board of Allergy and Immunology or by the American Osteopathic Association (AOA); **AND**

2. Provide documentation from the Applicant's outpatient practice setting to include five (5) cases of management of drug, environmental, animal, chemical, plant and/or food allergy; two (2) cases of allergen desensitization; and one (1) case of management of Immunodeficiency disorder (e.g., primary immunodeficiency, severe combined immunodeficiency). These must be cases that you have managed in the most recent two (2) years; **AND**

3. Submission of a Peer Review Evaluation Form completed by one of the Applicant's peers that refers patients to Appointee.

NOTE 1: Physicians must apply for "CORE" privileges in order to be eligible for clinical privileges in the specialty of Allergy & Immunology at any facility within Atrium Health.

NOTE 2: "CORE" privileges cannot be amended or altered in any way.

NOTE 3: Please note that the exercise of certain privileges enumerated herein is necessarily limited by the operational, and resource constraints of the facility. All procedures must be performed within a clinical setting with the capabilities and organizational structure required to provide appropriate support.

Please check appropriate blocks when applying for privileges:

CMC	PVL	UNV	CR	LIN	CAB	UNN	STN	ANS	CLV		ALLERGY AND IMMUNOLOGY CORE PRIVILEGES
			N/A						N/A	CALL-1	Privileges to evaluate, diagnose, and manage patients of all ages presenting with conditions or disorders involving the immune system, both acquired and congenital.
NOTE: Privileges include but are not limited to: asthma, anaphylaxis, rhinitis, eczema, urticaria, and adverse reactions to drugs, foods, and insect stings as well as immune deficiency diseases (both acquired and congenital), defects in host defense, and problems related to autoimmune disease, organ transplantation or malignancies of the immune system. Privileges also include allergy testing and desensitization. These core privileges do not include any of the special procedures listed below.											

Maintenance Criteria for Continued Privileges:

1. In order to be eligible for reappointment the Appointee shall demonstrate current clinical competence by providing documentation of three (3) inpatient consultations within the most recent two (2) years; **AND**
2. Submission of a Peer Review Evaluation Form completed by one of the Appointee's peers that refers patients to Appointee;

OR

1. Provide documentation from the Appointee's outpatient practice setting to include five (5) cases of management of drug, environmental, animal, chemical, plant and/or food allergy; two (2) cases of allergen desensitization; and one (1) case of management of Immunodeficiency disorder (e.g., primary immunodeficiency, severe combined immunodeficiency). These must be cases that you have managed in the most recent two (2) years; **AND**
2. Submission of a Peer Review Evaluation Form completed by one of the Appointee's peers that refers patients to Appointee.

CMC	PVL	UNV	CR	LIN	CAB	UNN	STN	ANS	CLV		**CORE ALLERGY & IMMUNOLOGY PRIVILEGES – REHABILITATION HOSPITAL SETTING <u>ONLY</u>**
N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	CALL-2	Privileges include evaluation and management, as well as procedures approved for performance within the acute rehabilitation setting, in conjunction with the comprehensive rehabilitation treatment plan.

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 at Atrium Health and;

I understand that:

a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

<u>I attest that I am not currently a user of illegal drugs or do not currently abuse the use of legal drugs.</u>

<u>I attest that I do not have a physical or mental condition which could affect my motor skills or ability to exercise the clinical privileges requested or that I require an accommodation in order to exercise the privileges requested safely and competently.</u>

_____ _____
Signature Date

_____
Print Name