

FLOYD CHEROKEE MEDICAL CENTER

Medical Staff Privilege Checklist

Department of Pediatrics

Pediatric Privileges Requested By: _____

☐ Board Qualified ☐ Board Certified

Staff Category _____ Department _____

Please check all categories and privileges desired. All privileges are first approved by the Credentials Committee and the Medical Executive Committee. Final approval is granted by the Governing Board. **For privileges not requested, enter Ø.**

☐ *I request privileges ordinarily permitted a Pediatrician who has been certified by the American Board of Pediatrics, or who has fulfilled the qualification requirements of the Board, including the following checked surgical, diagnostic, and therapeutic procedures:*

☐ *I request privileges for the following checked surgical, diagnostic, and therapeutic procedures in the Department of Pediatrics.*

I. *Pediatric Privileges (Privileges to perform emergency lifesaving procedures are automatically granted to all staff physicians.)*

☐ **Category 0**

Privileges usually granted a non-pediatrician specialty consultant who, in the opinion of the attending physician and Chief of Pediatrics, is capable of performing diagnostic consultation and/or specialty services urgently needed in the care of a critically ill patient or one with a diagnostic problem.

☐ **Category 1**

Illness or problem with no apparent serious threat to life. This category is usually granted to family physicians or internists.

☐ **Category 2**

Illness or problem requiring skills usually acquired after one year of pediatric training or the equivalent in experience.

☐ **Category 3**

Complex or severe illness or potentially life-threatening problems usually requiring skills acquired after pediatric training sufficient for Board eligibility/certification or the equivalent in experience. **This includes the stabilization of a critically ill child prior to transport to tertiary care facility including ventilator care.**

☐ **Category 4**

Intensive care of children, including ventilator care and advanced life support **prior to transport to tertiary care facility.**

☐ **Category 5**

Illness or problem requiring expertise acquired only during a subspecialty training or similar experience.

Subspecialty practice: _____

Neonatology _____

Pediatric Cardiology _____

Pediatric Gastroenterology _____

Pediatrics

Pediatric Neurology____

(This category does not necessarily include all others. Please check other categories desired.)

I. Neonatal Care Privileges

- ☐ **Class A**
(For those requesting Category 1, 2, 3, or 4) Normal care of newborn infants 2,000 gm.
- ☐ **Class B**
(For those requesting Category 3 or 4) Care of preterm or low-birth-weight infants with non-life-threatening illness, and not requiring ventilator support.
- ☐ **Class C**
(For those requesting Category 3 or 4) Care of all newborn infants, including those with potentially life-threatening illness, but excluding ventilator care and advance life support aspects.
- ☐ **Class D**
Intensive care of the newborn infant, including ventilator care, advanced life support, and chest tube insertion.

II. Surgical Procedures (Venipuncture, laceration repair, incision and drainage of superficial abscesses are automatically permitted):

- | | |
|--|---|
| <input type="checkbox"/> Neonatal Circumcision | <input type="checkbox"/> Peripheral venous cut-down |
| <input type="checkbox"/> Exchange transfusion | <input type="checkbox"/> Simple fracture and dislocations |
| <input type="checkbox"/> Umbilical catheterization | |
| <input type="checkbox"/> Intubation | |
| _____ (Specify inclusive ages) | |

Other:

III.B. Diagnostic Procedures

- | | |
|---|---|
| <input type="checkbox"/> Bladder tap | <input type="checkbox"/> Abdominal paracentesis |
| <input type="checkbox"/> Subdural tap | <input type="checkbox"/> Thoracentesis |
| <input type="checkbox"/> Skin biopsy | <input type="checkbox"/> Lumbar puncture |
| <input type="checkbox"/> Laryngoscopy | |
| <input type="checkbox"/> Peripheral puncture arterial | |
| _____ (Specify inclusive ages) | |

Other:

Additions/Deletions/Conditions/Other Limitations:

Pediatrics

Acknowledgement of practitioner

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform, and that I wish to exercise at Floyd Cherokee Medical Center, and I understand that:

1. 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.
2. 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.
3. All members of the medical staff are required to treat patients, their families, hospital staff, and colleagues in a respectful and professional manner at all times. Each member of the medical staff is expected to comply with hospital and medical staff code of conduct policies. Failure to do so may be the basis for dismissal.

Applicant Signature _____ Date: _____

APPROVED:

Credentials Committee Chairman

Date

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

- ☐ Concur with Credential Committee's recommendation and forward to governing body
- ☐ Return to Credentials Committee for clarification of the following:

Date

BOARD APPROVAL

_____ Yes _____ No

Date