**SCOTLAND MEMORIAL HOSPITAL**
**Clinical Privilege Delineation Form**
**Specialty: *OCCUPATIONAL MEDICINE***

PHYSICIAN NAME: _____

I. ***General Privileges***

By virtue of being granted any level of clinical privileges, a physician is automatically granted the following privileges:

Performing physical examinations and ordering and interpreting of diagnostic studies that are normally considered part of the practice of occupational medicine, including, but not limited to, laboratory, diagnostic imaging, and electrocardiographic studies.

Prescribing and administering medications normally considered part of the practice of occupational medicine.

At the time of a clinical emergency, the provision of whatever care the physician beleives to be indicated to prevent loss of life or serious injury to a patient.

II. ***Specific Privileges: Clinical***

Three categories of clinical privileges may be granted for each clinical area listed on the following page. The category of privileges being requested, if any, must be indicated next to the specific clinical area being addressed.

**Category 1:** Uncomplicated illnesses or problems that present no serious threat to life, and which are expected to require only a short period of hospitalization. When doubt exists as to the diagnosis, or in cases in which improvement from treatment is not apparent, consultation must be obtained.

**Category 2:** Major illnesses, injuries, or conditions, but with no significant risk to life. When doubt exists as to the diagnosis, or in cases in which improvement from treatment is not apparent, consultation must be obtained.

**Category 3:** Major illnesses, injuries, or conditions that carry substantial threat to life. When doubt exists as to the diagnosis, or in cases in which improvement from treatment is not apparent, consultation must be obtained.

***CLINICAL AREAS***: In the area marked "Level of Privileges Requested" **circle** the number indicating the level of privileges that you wish to be granted in each of the areas listed.

***GENERAL MEDICAL PRIVILEGES***

| Area | Level of Privileges Requested | Approved | Not Approved/ Approved with Restrictions | Area | Level of Privileges Requested | Approved | Not approved/ Approved with Restrictions |
|---|---|---|---|---|---|---|---|
| Surturing of simple or complex lacerations | 1 2 3 | | | Treatment of uncomplicated burns | 1 2 3 | | |
| I & D of abscesses | 1 2 3 | | | Local anesthesia | 1 2 3 | | |
| Simple skin biopsy or excision | 1 2 3 | | | Regional nerve blocks | 1 2 3 | | |
| Removal of non-penetrating foreign body in cornea | 1 2 3 | | | Arthrocentesis | 1 2 3 | | |
| Uncomplicated removalof foreign objects | 1 2 3 | | | Nail trephination | 1 2 3 | | |
| Treatment of uncomplicated minor closed fractures not involving skeletal traction or major manipulation/reduction | 1 2 3 | | | Nail removal | 1 2 3 | | |
| Treatment of uncomplicated dislocations of the upper & lower extremities, excluding the hip & knee | | | | Wound management | | | |

I hereby request the clinical privileges indicated above. Date: _____/_____/_____ Initials: _____

***DEPARTMENT CHAIRMAN APPROVAL***

***NOTE:*** Any request indicated as "Not Approved or Approved with Restrictions" must be explained here, including listing any restrictions:

_____

_____

_____

I have reviewed this application and recommend clinical privileges as indicated above.

_____ _____

Chairman, Department of Internal Medicine Date

***SURGICAL PRIVILEGES***

| ***Procedure*** | ***Requested*** | ***Approved*** | ***Not Approved/ Approved with Restrictions*** | ***Procedure*** | ***Requested*** | ***Approved*** | ***Not Approved/ Approved with Restrictions*** |
|---|---|---|---|---|---|---|---|
| *Suturing of simple or complex lacerations* | | | | ***Treatment of uncomplicated dislocations of the upper & lower extremeties, excluding the hip & knee*** | | | |
| *I&D of abscesses* | | | | | | | |
| *Simple skin biopsy or excision* | | | | ***Treatment of uncomplicated burns*** | | | |
| *Removal of non-penetrating foreign body in cornea* | | | | | | | |
| *Uncomplicated removal of foreign objects* | | | | ***Other:***<br><br>***Local Anesthesia*** | | | |
| *Treatment of uncom-plicated minor closed fractures not involving skeletal traction or major maipulation/reduction* | | | | ***Other:***<br><br>***Regional nerve blocks*** | | | |

I hereby request the clinical privileges indicated above. Date: _____/_____/_____ Initials: _____

***DEPARTMENT CHAIRMAN APPROVAL***

***NOTE:*** Any request indicated as "Not Approved/Approved with Restrictions" must be explained here, including listing any restrictions:

_____

_____

_____

I have reviewed this application and recommend clinical privileges as indicated above.

_____ _____

Chairman, Department of Internal Medicine Date