

**SCOTLAND MEMORIAL HOSPITAL
CLINICAL PRIVILEGE DELINEATION FORM
Specialty: PATHOLOGY**

Applicant: _____

Procedure	Requested	Approved	Not Approved /Approved with Restrictions
ANATOMIC PATHOLOGY			
Cytology			
Fine Needle Biopsy			
Surgical Pathology			
Autopsy Pathology			
Cytopathology			
Neuropathology			
Dermatopathology			
CLINICAL PATHOLOGY			
Bacteriology			
Chemistry			
Hematology			
Immunohematology			
Myocology			
Parasitology			
Serology			
Virology			
Bone marrow aspiration & smears			
Blood Transfusion Technology			
FORENSIC PATHOLOGY			
NUCLEAR MEDICINE			
ARTERIAL PUNCTURE			

I hereby request the clinical privileges listed above.

Applicant Signature: _____

Date: ____ / ____ / ____

CHIEF OF STAFF APPROVAL

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

Chief of Staff

Date