

Community Health Services

Physician Privileging Form

Family Practice/Internal Medicine/Pediatrics/Obstetrics/Podiatry

Print Name: _____ Date: _____ Hire Date: _____

Assignment of clinical privileges are based upon education, clinical training, experience, demonstrated current competence, documented results of patient care, and other quality review and monitoring deemed appropriate.

1. General Privileges

Site For Requested General Privileges _____
General Privileges Requested _____ initials
Medical Director Approval _____ initials
Special Conditions/Comments:

2. In addition to general privileges check the following procedures that you perform within the scope of your office practice.

Procedure	Privileges Requested	Site	Medical Director	Date
Casting-simple/compound Fracture	_____	_____	_____	_____
Reduction of Fractures Open and Closed	_____	_____	_____	_____
Circumcision	_____	_____	_____	_____
Colposcopy	_____	_____	_____	_____
Fetal Ultrasound	_____	_____	_____	_____
Flew Sigmoidoscopy	_____	_____	_____	_____
General Ultrasound	_____	_____	_____	_____
Gyn Cryotherapy	_____	_____	_____	_____
LEEP	_____	_____	_____	_____
Lumbar Puncture	_____	_____	_____	_____
Sclerotherapy	_____	_____	_____	_____
Stress Test	_____	_____	_____	_____
Vasectomy	_____	_____	_____	_____
Basic Cardiac Life Support	_____	_____	_____	_____
Pediatric Cardiac Life Support	_____	_____	_____	_____

Procedure	Privileges Requested	Site	Medical Director	Date
Toe Nail Removal	_____	_____	_____	_____
Casting for Deformities	_____	_____	_____	_____
Design Machine Services For Balance	_____	_____	_____	_____
Fit Corrective Inserts (Orthotics)	_____	_____	_____	_____
Excisional Biopsy >3mm	_____	_____	_____	_____
Joint Aspirations and/or Inject	_____	_____	_____	_____
Norplant Insertion and Removal	_____	_____	_____	_____
Invasive Podiatric Procedures	_____	_____	_____	_____

Special Conditions/Comments:

3. List any continuing medical education units or training that you have received related to performing these procedures and attach copies of certificates of attendance.

Name of Training	Date	Sponsoring Institution	CME hours
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Continuing Medical Education (CME):

A. Do you have enough CME hours to satisfy the requirements for licensure by the state from which you hold your license to practice your profession?

Yes _____ No _____

B. Are the stated CME hours related mostly to your specialty?

Yes _____ No _____

Privileges Recommended: Approved: _____ Denied: _____ Modified: _____

Additional Comments:

Approval

Physician

Date

Medical Director

Date

Chief Executive Officer

Date

Board Chairperson

Date

