Huntington Hospital

**Delineation Of Privileges**

Anatomic & Clinical Pathology

Provider Name:

| Privilege | Requested | Tabled | Approved |
|---|---|---|---|
| | | | |

**PATHOLOGY - CATEGORY I PRIVILEGES**

***Criteria:***

a) Board Certification or qualified for certification by the American Board of Pathology; OR,
b) Successful completion of an ACGME or AOA approved Pathology training program requiring certification by a Training Director regarding experience and demonstrated competence to perform the procedure(s) being requested.

***Proctoring Requirements:*** A minimum of eight (8) cases, in accordance with the Medical Staff Proctoring Protocol.

**PATHOLOGY - CATEGORY I PRIVILEGES:**

| | | | |
|---|---|---|---|
| **General Surgical Pathology:** | ___ | ___ | ___ |
| a) Routine - gross and microscopic | ___ | ___ | ___ |
| b) Frozen sections | ___ | ___ | ___ |
| c) Emergency consultation (i.e. OR consultation with/without frozen section diagnosis) | ___ | ___ | ___ |
| d) Cytology - cervical, vaginal | ___ | ___ | ___ |
| e) Cytology - special (fluids, sputum, urine) | ___ | ___ | ___ |
| f) Cytology - needle aspirations | ___ | ___ | ___ |
| Neuropathology | ___ | ___ | ___ |
| Autopsy pathology (adult and pediatric) | ___ | ___ | ___ |
| **Clinical Pathology:** | ___ | ___ | ___ |
| a) Blood banking | ___ | ___ | ___ |
| b) Clinical chemistry | ___ | ___ | ___ |
| c) Hematology | ___ | ___ | ___ |
| d) Microbiology | ___ | ___ | ___ |
| e) Sample collection: | ___ | ___ | ___ |

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|---|---|---|---|
| 1) Bone Marrow | ___ | ___ | ___ |
| 2) Fine needle biopsy | ___ | ___ | ___ |

**ACKNOWLEDGEMENT OF THE PRACTITIONER:**

I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at Huntington Hospital, and I understand that: a) in exercising my 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.

**Signature of Applicant: _____ Date:_____**

**DEPARTMENT CHAIR RECOMMENDATIONS**

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Applicant may perform privileges and procedures as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

**APPROVALS:**

**Department Chair: _____ Date: _____**

**Credential Committee Approved on: _____**

**Medical Executive Committee Approved on: _____**

**Board of Directors Approved on: _____**