Huntington Hospital

Delineation Of Privileges

Dermatology Privileges

Provider Name:

Privilege	Requested	Tabled	Approved

Dermatology Privilege Criteria:

a) Board Certification or qualified for certification by the American Board of Dermatology; OR

b) Successful completion of an ACGME or AOA approved Dermatology Residency program requiring certification by a Training Director regarding experience and demonstrated competence.

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

GENERAL PRIVILEGES:

Admitting Privileges	___	___	___
Consultation Only Privileges	___	___	___
Sedation Analgesia ***Criteria:*** Successful completion of the Sedation Assessment Test. ***Additional criteria effective April 1, 2015:*** a) Evidence of current ACLS and/or PALS from the American Heart Association; AND b) Evidence of completion of an Airway Management Course	___	___	___
a) Adult Sedation	___	___	___
b) Pediatric Sedation (17 years and under)	___	___	___

CORE DERMATOLOGY PRIVILEGES ___ ___ ___

Includes the management and coordination of care, treatment and services including: History and Physical examinations, consultations, prescribing medications according to DEA Certificate, and the diagnosis and medical treatment of simple general medical problems of the skin or other organs in patients with dermatological conditions. (ACC)

Verrucae (ACC)	___	___	___
Herpes simplex and zoster (ACC)	___	___	___
Uncomplicated acne vulgaris (ACC)	___	___	___
Seborrheic dermatitis (ACC)	___	___	___
Uncomplicated tinea (ACC)	___	___	___
Neurodermatitis (ACC)	___	___	___

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Provider Name:

Privilege	Requested	Tabled	Approved
Nummular dermatitis (ACC)	___	___	___
Dyhidrosis (ACC)	___	___	___
Uncomplicated viral exanthems (ACC)	___	___	___
Obvious drug eruption (ACC)	___	___	___
Scabies (ACC)	___	___	___
Pediculosis (ACC)	___	___	___
Conditions requiring routine excision and drainage of cysts and routine biopsies (ACC)	___	___	___
Uncomplicated psoriasis (ACC)	___	___	___
Uncomplicated actinic keratoses (ACC)	___	___	___
Uncomplicated basal cell and squamous cell carcinoma (ACC)	___	___	___
Administration and interpretation of patch skin testing and intradermal tests	___	___	___
Administration and interpretation of photo-testing and photo-patch testing	___	___	___
Review of dermatologic pathology slides as interpreted by the Department of Pathology in order to correlate with the clinical disease state (ACC)	___	___	___
Diagnosis and treatment of more complex life threatening or disfiguring dermatologic disorders	___	___	___
Surgical procedures, electrocautery or destructive techniques, including:	___	___	___
a) Routine biopsy or excision relating to a dermatology problem (ACC)	___	___	___
b) Hair transplants	___	___	___
c) Pinch, split and full thickness grafts	___	___	___
d) Lip wedges/shaves	___	___	___

Provider Name:

Privilege	Requested	Tabled	Approved
e) Chemical face peels	___	___	___
f) Dermabrasion	___	___	___

DERMATOLOGY SUPPLEMENTAL PRIVILEGES

Criteria: Applicants must meet the criteria outlined for Core Dermatology privileges and provide documentation of training and/or current clinical competency in each of the supplemental privileges requested.
Proctoring Requirements: A minimum of one case for each privilege requested.

Mohs Type Chemotherapy ___ ___ ___
Includes all aspects of patient management entailed by the performance of procedures in the Mohs Surgery by both "in situ" fixation and fresh tissue techniques.
Competency Requirements: Evidence of performing at least three (3) procedures over a two-year period.

X-ray therapy for dermatologic conditions ___ ___ ___
Competency Requirements: Evidence of performing at least three (3) procedures over a two-year period.

Rotation of skin flaps ___ ___ ___
Competency Requirements: Evidence of performing at least three (3) procedures over a two-year period.

Plasmapheresis ___ ___ ___
Competency Requirements: Evidence of performing at least three (3) procedures over a two-year period.

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:_____

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Delineation Of Privileges

Dermatology Privileges

Provider Name:

Privilege	Requested	Tabled	Approved

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:

Section Chair: _____ Date: _____

Department Chair: _____ Date: _____

Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____