Huntington Memorial Hospital
Delineation Of Privileges
Neonatology Privileges

Provider Name: ____

Privilege	Requested	Deferred	Approved

NEONATOLOGY PRIVILEGES
NEONATOLOGY CORE PRIVILEGES
1. Successful completion of an ACGME or AOA accredited residency in General Pediatrics.
2. Board certification or in the process of certification by the American Board of Pediatrics, Sub-Board in Neonatal Perinatal Medicine or have equivalent qualifications.
3. Demonstrated competence in Category I privileges.
4. Maintains current CME activities in the division of Neonatology or equivalent.
5. Must be CCS paneled.
6. Successful completion of NRP.

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

GENERAL PRIVILEGES:

Admitting Privileges ___ ___ ___

Consultation Only Privileges ___ ___ ___

Sedation Analgesia ___ ___ ___
Criteria: Requires successful completion of the Sedation Assessment Test.

NEONATOLOGY CORE PRIVILEGES ___ ___ ___
Includes the management and coordination of care, treatment and services, including: medical history and physical examinations, consultations and prescribing medication in accordance with DEA certificate.

Management of patients in the Newborn Nursery ___ ___ ___
Criteria: Requires one-time completion of the Breast Feeding Management course/test. Confirmation of previous completion is acceptable.
(www.wellstart.org - click on "BFUSA Physician Training and Certification Process")

Management of the following conditions:

a) Diabetic Ketoacidosis ___ ___ ___

b) Status asthmaticus with respiratory insufficiency ___ ___ ___

c) Extreme prematurity ___ ___ ___

Provider Name: ____

Privilege	Requested	Deferred	Approved
d) Respiratory Distress Syndrome, Respiratory insufficiency	___	___	___
e) Meconium aspiration syndrome	___	___	___
f) Persistent pulmonary hypertension of the newborn	___	___	___
g) Respiratory or Metabolic acidosis	___	___	___
h) Hyperglycemia or hypoglycemia	___	___	___
i) Electrolyte imbalance	___	___	___
j) Dehydration	___	___	___
k) Anemia	___	___	___
l) Hyperbilirubinemia	___	___	___
m) Polycithemia	___	___	___
n) Meningitis	___	___	___
o) Recurrent seizure disorders	___	___	___
p) Perinatal asphyxia	___	___	___
q) Hypoxic ischemic encephalopathy	___	___	___
r) Advanced neonatal resuscitation	___	___	___
s) Renal dysfunction	___	___	___
t) Upper airway obstruction	___	___	___
u) Chronic lung disease (Bronchopulmonary dysplasia) and Reactive airway disease	___	___	___
Arterial puncture	___	___	___

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Neonatology Privileges

Provider Name: ______________________________

Privilege	Requested	Deferred	Approved
Endotracheal intubation	___	___	___
Lumbar puncture	___	___	___
Newborn resuscitation	___	___	___
Suprapubic puncture	___	___	___
Venous cutdown	___	___	___
Wound aspiration	___	___	___
Incision and Drainage of superficial abscesses, excision of subcutaneous cysts or tumors; and subcutaneous foreign body removal	___	___	___
Arterial lines: cutdown; percutaneous; umbilical	___	___	___
Closed thoracostomy	___	___	___
Paracentesis	___	___	___
Exchange transfusion	___	___	___
Parenteral nutrition	___	___	___
Thoracentesis	___	___	___
Peripheral arterial cut-down	___	___	___
Management of ventilators	___	___	___
Management of oscillators	___	___	___
ECMO	___	___	___
Pericardiocentesis	___	___	___
Administration of Nitric Oxide	___	___	___

Provider Name: ____

Privilege	Requested	Deferred	Approved

NEONATOLOGY - SUPPLEMENTAL PRIVILEGES
Advanced Privileges - Procedures performed requiring special expertise and/or requiring documented special training and/or certification when it exists

1. Requires documentation of ability to perform the procedure(s) as outlined below:
   - Documentation of training and experience in the advanced procedure, OR
   - Additional fellowship training and certification by a training director with experience and demonstrated competence in the procedure requested.

Privilege	Requested	Deferred	Approved
Circumcision ***Proctoring Requirements:*** A minimum of five (5) cases, in accordance with the Medical Staff Proctoring Protocol.	___	___	___
Bronchoscopy (flexible) ***Proctoring Requirements:*** A minimum of two (2) cases, in accordance with the Medical Staff Proctoring Protocol.	___	___	___
Frenulectomy ***Proctoring Requirements:*** A minimum of two (2) cases, in accordance with the Medical Staff Proctoring Protocol.	___	___	___

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:___________________________

Provider Name: ____

Privilege	Requested	Deferred	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:

Department Chair ________________________________ **Date: ________________**

Credential Committee Date: __________

Medical Executive Committee Date: __________

Board of Directors Approved on: __________

Revised: 02/27/2014