Delineation Of Privileges

Nephrology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

NEPHROLOGY - CORE PRIVILEGES

Criteria:
a) Active licensure to practice medicine in the state of California

b) Current board certification or active participation in the examination process leading to certification by the American Board of Internal Medicine or American Osteopathic Board of Internal Medicine with subspecialty certification in Nephrology, with achievement of certification within 4 (four) years of initial appointment;

OR (if on staff prior to July 1, 2011)

Successful completion of an ACGME or AOA approved training program in Nephrology, requiring verification by a Training Director regarding experience and demonstrated competence to perform the procedure(s) being requested.

c) Demonstrated evidence of ongoing clinical practice for a minimum of 5 (five) years OR, successful completion of an ACGME or AOA accredited residency/clinical fellowship within the past 24 months, reflective of the scope of privileges requested.
Proctoring Requirements: A minimum of eight (8) cases, in accordance with the Medical Staff Department Rules and Regulations.

GENERAL PRIVILEGES:	___	___	___
Admitting privileges	___	___	___
Consult 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 certification 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)	___	___	___
NEPHROLOGY CORE PRIVILEGES Includes the management and coordination of care, treatment and services for renal disease, including; Medical history and physical examinations, consultations, and prescribing medication in accordance with DEA certificate.	___	___	___
Arterial puncture (blood gas)	___	___	___
Patient-controlled analgesia (PCA)	___	___	___
TPN Management	___	___	___

NEPHROLOGY - SUPPLEMENTAL PRIVILEGES

Criteria: Applicants must meet the criteria outlined for Core Nephrology privileges;

Proctoring Requirements: A minimum of 1 (one) case for each Supplemental privilege requested.

Requirements: As outlined under each Supplemental privilege below.

NEPHROLOGY SUPPLEMENTAL PRIVILEGES	___	___	___
Subclavian vein catheter placement ***Competency Requirement:*** Evidence of performing at least three (3) procedures over a two-year period.	___	___	___

Delineation Of Privileges

Nephrology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Internal jugular catheter placement ***Competency Requirement:*** Evidence of performing at least three (3) procedures over a two-year period.	___	___	___
Femoral vein catheter placement ***Competency Requirement:*** Evidence of performing at least three (3) procedures over a two-year period.	___	___	___
Ventilator Management of all renal disease ***Competency Requirement:*** Evidence of performing at least three (3) procedures over a two-year period.	___	___	___
Peritoneal dialysis ***Competency Requirement:*** Evidence of performing at least one (1) procedure over a two-year period.	___	___	___
Hemodialysis/Hemoperfusion ***Competency Requirement:*** Evidence of performing at least three (3) procedures over a two-year period.	___	___	___
Kidney biopsy, percutaneous ***Competency Requirement:*** Evidence of performing at least three (3) procedures over a two-year period.	___	___	___
Plasmapheresis / Apheresis Procedures ***Competency Requirement:*** Evidence of performing at least one (1) procedure over a two-year period.	___	___	___
Administration of immunosuppresive medications including those with cytotoxic properties (chemotherapy) ***Competency Requirement:*** Evidence of performing at least one (1) procedure over a two-year period.	___	___	___

Last Revised: 5/25/06; 07/28/11; 01/29/16

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:

Delineation Of Privileges

Nephrology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

Department Chair: _____ **Date:** _____

Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____

Revised 01/29/16 ___ ___ ___