Huntington Memorial Hospital

Delineation Of Privileges

Physical Medicine and Rehabilitation

Provider Name:

Privilege	Requested	Deferred	Approved

PHYSICAL MEDICINE AND REHABILITATION 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 Physical Medicine and Rehabilitation or the American Osteopathic Board of Physical Medicine and Rehabilitation and/or subspecialty certification in either Pain Management or Spinal Cord Injury Medicine or qualified for certification by the American Board of Physical Medicine and Rehabilitation and/or subspecialty certificate in Pain Management and/or subspecialty certificate in Spinal Cord Injury Medicine;

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

Successful completion of an ACGME or AOA approved Physical Medicine and Rehabilitation training program requiring certification 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 (twenty-four) months, reflective of the scope of privileges requested..
Proctoring Requirement: A minimum of eight (8) cases, in accordance with the Medical Staff Proctoring Protocol.

GENERAL PRIVILEGES:	___	___	___
Admitting privileges	___	___	___
Consultation Only Privileges	___	___	___
Sedation Analgesia ***Criteria:***	___	___	___

a) Requires successful completion of the Sedation Assessment Test
b) Evidence of current ACLS and/or PALS certification from the American Heart Association; AND

c) Evidence of completion of an Airway Management Course

a) Adult Sedation	___	___	___
b) Pediatric Sedation (17 years and under)	___	___	___
PHYSICAL MEDICINE AND REHABILITATION CORE PRIVILEGES: Includes the management and coordination of care, treatment and services, including: Medical history and physical examinations, consultations and prescribing medication according to DEA Certificate.	___	___	___
Amputees, upper and lower extremities	___	___	___
Arthritis syndromes	___	___	___
Congenital deformities	___	___	___
Head/brain injuries	___	___	___
Hip fractures	___	___	___
Major/multiple trauma	___	___	___
Neurological disorders (ALS, muscular dystrophy, multiple sclerosis, neuropathies, parkinsons)	___	___	___
Neuromuscular disease/syndromes - Peripheral vascular disease - Prosthetics and orthotics	___	___	___
Peripheral vascular disease	___	___	___

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Prosthetics and orthotics	___	___	___
Skin/wound care (decubitus)	___	___	___
Spinal cord syndromes	___	___	___
Stroke syndromes	___	___	___
Trauma, sports or industrial injuries	___	___	___
Urological syndromes	___	___	___
Athrocentesis, aspiration and injection	___	___	___
Electrodiagnosis:	___	___	___
a) Strength duration curves	___	___	___
b) Electromyography	___	___	___
c) Electromyography with computer analysis	___	___	___
d) Nerve conduction studies - motor and sensory	___	___	___
e) Evoked potentials	___	___	___
Serial casting	___	___	___
Soft tissue injection, ligaments and tendons	___	___	___
Soft tissue injection, trigger points	___	___	___
Soft tissue mobilization	___	___	___
Distal nerve block	___	___	___

PHYSICAL MEDICINE AND REHABILITATION SUPPLEMENTAL PRIVILEGES

Criteria: Must meet the criteria outlined for Core Physical Medicine and Rehabilitation privileges

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

Competency Requirement: Evidence of performing at least 3 (three) procedures over a 2 (two) year period.

Peripheral nerve and motor points block	___	___	___

Last Revised: 5/25/06

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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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 01/29/16 ___ ___ ___