Hospital Logo

Hospital Name

Hospital Address

**Application for Clinical Privileges – Pathology**

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| Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff Category: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effective from \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Request all privileges desired by checking the applicable requested box.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Request | Not Requested |  | Granted | Not Granted |
|  |  | Anatomic Pathology: Patient diagnosis, ordering, consultation, and laboratory medical direction in the following disciplines: surgical pathology (including intraoperative consultations), cytopathology, autopsy pathology, molecular pathology, and associated ancillary studies. Adherence to medical staff policy regarding emergency and consultative call services. The core privileges include the procedures listed on the attached privileges list and such other procedures that are extensions of the same techniques and skills. |  |  |
|  |  | Clinical Pathology: Patient diagnosis, ordering, consultation, and laboratory medical direction in the following clinical pathology disciplines: hematology and coagulation, blood bank and immunohematology, microbiology, serology, molecular pathology, clinical chemistry (including the subdivisions of special chemistry, automated chemistry, endocrinology, radioimmunoassay, toxicology, and electrophoresis), clinical microscopy, and other routine clinical pathology functions. Adherence to medical staff policy regarding emergency and consultative call services. The core privileges include the procedures listed on the attached privileges list and such other procedures that are extensions of the same techniques and skills. |  |  |
|  |  | Cytopathology: Diagnosis of human disease by means of the study of cells (from all systems and areas of the body) obtained from body secretions and fluids by scraping, washing, or sponging the surface of a lesion or by the aspiration of a tumor mass or body organ with a fine needle. Adherence to medical staff policy regarding emergency and consultative call services. The core privileges include the procedures listed on the attached privileges list and such other procedures that are extensions of the same techniques and skills. |  |  |
|  |  | Chemical pathology |  |  |
|  |  | Dermatopathology |  |  |
|  |  | Forensic pathology |  |  |
|  |  | Hematology |  |  |
|  |  | Medical microbiology |  |  |
|  |  | Neuropathology |  |  |
|  |  | Radioisotope pathology |  |  |
|  |  | Bone marrow aspiration and biopsy |  |  |
|  |  | Perform fine needle aspiration or palpable soft tissue mass |  |  |
|  |  | Blood banking |  |  |
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|  |  | Other Privileges Desired (Not Listed Above) |  |  |
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**Signature of Applicant:**

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I am entitled to perform and that I wish to exercise at (Insert Name of Hospital).

I also understand that by making this request I am bound by the applicable Medical Staff Bylaws and/or policies of (Insert Name of Hospital). I also attest that my professional liability insurance covers the privileges I have requested.

I understand that it is my responsibility to provide (Insert Name of Hospital) with documentation of my education, training, current experience and information regarding the number of services and procedures I have performed in order to assist the Medical Staff in the determination of competency or continued competency.

I affirm that I will obtain a consultation with a qualified medical staff member when it is in the best interest of the patient and/or when my expertise does not meet the clinical needs of the patient.

Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws and related documents.

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**Signature of Applicant Date**

**Medical Staff/Credentials Committee Recommendations – Privileges**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s): Please check the applicable box(es)

|  |  |
| --- | --- |
|  | Recommend all requested privileges |
|  | Do not recommend any of the requested privileges |
|  | Recommend privileges with the following conditions/modifications/deletions (listed below) |

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| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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**Medical Staff/Credentials Committee Date**

**Board of Directors Determination**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following determination(s): Please check the applicable box(es).

|  |  |
| --- | --- |
|  | Approve all requested privileges |
|  | Approve none of the requested privileges |
|  | Approve the following privileges with the following conditions/modifications/deletions (listed below) |

|  |  |
| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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Board of Directors Date

Hospital Name

Form Approved By:

Medical Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date

Board of Directors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date