Hospital Logo

Hospital Name

Hospital Address

**Application for Clinical Privileges – Dermatology**

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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 |
|  |  | Evaluate, diagnose, treat, and provide consultation to patients of all ages, with benign and malignant disorders of the skin, mouth, external genitalia, hair, and nails, as well as sexually transmitted diseases. Includes the diagnosis and treatment of skin cancers, melanomas, moles, and other tumors of the skin, management of contact dermatitis and other allergic and nonallergic skin disorders, cosmetic disorders of the skin such as hair loss and scars, the skin changes associated with aging, and recognition of skin manifestations of systemic and infectious diseases. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services |  |  |
|  |  | Admit patients to the appropriate level of care |  |  |
|  |  | **Procedure: Remove those procedures not within the capabilities and capacities of Hospital** |  |  |
|  |  | Botulinum toxin injection |  |  |
|  |  | Chemical face peels |  |  |
|  |  | Collagen injections |  |  |
|  |  | Cryosurgery |  |  |
|  |  | Destruction of benign and malignant tumors |  |  |
|  |  | Electrosurgery |  |  |
|  |  | Excision of benign and malignant tumors with simple, intermediate and complex repair techniques including flaps and grafts |  |  |
|  |  | Intralesional injections |  |  |
|  |  | Patch tests |  |  |
|  |  | Photomedicine, phototherapy and topical/system pharmacotherapy |  |  |
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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) |

|  |  |
| --- | --- |
| 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