Huntington Memorial Hospital

Delineation Of Privileges
Nephrology Privileges

Provider Name:

Privilege	Requested	Tabled	Approved

NEPHROLOGY - CORE PRIVILEGES

Criteria:
a) Board certification by the American Board of Internal Medicine with a subspecialty certificate in Nephrology; OR;
b) Successful completion of an ACGME or AOA approved Nephrology training program.
Proctoring Requirements: A minimum of eight (8) cases, in accordance with the Medicine Department Rules and Regulations.

GENERAL PRIVILEGES:

Admitting privileges ___ ___ ___

Consult Only privileges ___ ___ ___

Sedation Analgesia ___ ___ ___
Criteria: Successful completion of the Sedation Assessment Test

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; AND provide certification by a Training Director regarding experience and demonstrated competence to perform the procedure(s) being requested.
Competency Requirements: As outlined under each Supplemental privilege below.
Proctoring Requirements: A minimum of one case for each Supplemental privilege requested.

NEPHROLOGY SUPPLEMENTAL PRIVILEGES

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

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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

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

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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:

Section/Department Chair: _____ Date: _____

Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____