

Regions Hospital Delineation of Privileges Allergy and Immunology

Applicant's Name:

Last

First

M.

- Instructions:
- Place a check-mark where indicated for each core group you are requesting.
 - Review *education and basic formal training* requirements to make sure you meet them.
 - Review *documentation and experience* requirements and be prepared to prove them.
 - ✓ Note all renewing applicants are required to provide evidence of their current ability to perform the privileges being requested
 - ✓ When documentation of cases or procedures is required, attach said case/procedure logs to this privileges-request form.
 - Provide complete and accurate names and addresses where requested -- it will greatly assist how quickly our credentialing-specialist can process your requests.

Overview

Core I – general privileges

Core procedure list

Signature page

☐ **CORE I — General privileges in allergy and immunology**

Privileges
<p>Admit, evaluate, diagnose, consult, and manage patients of all ages presenting with conditions or disorders involving the immune system, both acquired and congenital. Selected examples of such conditions include asthma, anaphylaxis, rhinitis, eczema, urticaria, and adverse reactions to drugs, foods, and insect stings.</p> <p>The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.</p>
Basic education and minimal formal training
<ol style="list-style-type: none">1. MD, DO, MBBS or MBBCH.2. Successful completion of an ACGME, AOA or Royal College of Physicians and Surgeons of Canada approved residency training program in internal medicine or pediatrics followed by at least two years of approved residency or fellowship in allergy and immunology; Or Completion of an approved ACGME AOA or Royal College of Physicians and Surgeons of Canada approved residency program in internal medicine, pediatrics, or family practice providing that such residency included a minimum of six months' training in pediatrics and adult allergy and immunology;3. Current certification or active participation in the examination process -- with achievement of certification within 5 years -- by the American Board of Allergy and Immunology or subspecialty certification in allergy and immunology by the American Osteopathic Board of Internal Medicine.
Required documentation and experience
<p>NEW APPLICANTS:</p> <ol style="list-style-type: none">1. Provide contact information for an allergy/immunology physician whom the credentialing specialist may contact to provide an evaluation of your competency. Name: _____ Name of Facility: _____ Address: _____ Phone: _____ Fax: _____ Email: _____ <p>REAPPOINTMENT APPLICANTS:</p> <ol style="list-style-type: none">1. Provide documentation showing the number of inpatient services performed during the past 24 months; Or Provide contact information for a physician-peer whom the credentialing specialist may contact to provide an evaluation of your competency. Name: _____ Name of Facility: _____ Address: _____ Phone: _____ Fax: _____ Email: _____

Core Procedure List — Allergy and Immunology Clinical Privileges

To the applicant: If you want to exclude any procedures, please strike through those procedures you do not wish to request.

This list is a sampling of procedures included in the core. This is not intended to be all-encompassing but rather reflective of the categories/types of procedures included in the core.

1. Allergen immunotherapy
2. Allergy testing
3. Delayed hypersensitivity skin testing
4. Drug desensitization and challenge
5. Drug testing
6. Food challenge testing
7. Immediate hypersensitivity skin testing
8. IVIG treatment and administration
9. Nasal cytology
10. Patch testing
11. Performance of history and physical exam
12. Physical urticaria testing
13. Provocation testing for hyper-reactive airways
14. pulmonary function tests
15. Rapid desensitization
16. Rhinolaryngoscopy

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which – by education training, current experience and demonstrated performance – I am qualified to perform and that I wish to exercise at Regions Hospital. I understand that:

1. In exercising any clinical privilege granted, I am governed by Regions Hospital and Regions Medical Staff policies and rules applicable generally and any applicable to the particular situation.
2. In an emergent situation I may perform a procedure for which I am not privileged when no practitioner holding the applicable procedure is available to respond to the emergency.

I agree to supply Regions Hospital Medical Staff Services (or designee) with all the information that has been requested of me for the privileges that I have applied for. I also understand that my application for privileges will not proceed until the information is received.

Signature

Date

DIVISION / SECTION HEAD RECOMMENDATION

I have reviewed and/or discussed the clinical privileges requested and supporting documentation for the above-named applicant and make the following recommendation/s:

- ☐ Recommend all requested privileges
- ☐ Recommend privileges with the following conditions/modifications
- ☐ Do not recommend the following requested privileges

Privilege	Condition / Modification / Explanation
1.	
2.	
3.	
4.	

Notes:

Signature

Date