Regions Hospital
Delineation of Privileges
Infectious Disease

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 in infectious disease
Core II - HIV / AIDS specialist
Core procedure list
Moderate sedation
Signature page

☐ CORE I — Infectious disease

Privileges

Admit, evaluate, diagnose, consult, and provide care for patients 16 years and above with acute and chronic infectious or suspected infectious or immunologic diseases, underlying diseases that predispose to unusual severe infections, unclear diagnoses, uncommon diseases, and complex or investigational treatments. This includes but is not limited to patients who are neutropenic, have HIV/AIDS, or are immune-compromised by other disease or medical therapies.

Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.

Core privileges include procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

Basic education and minimal formal training

1. MD, DO, MBBS or MB BCH.
2. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) - or American Osteopathic Association (AOA) - accredited residency in internal medicine and successful completion of a fellowship in infectious disease.
3. Current subspecialty certification or active participation in the examination process -- leading to subspecialty certification in infectious disease within 5 years -- by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.

Required documentation and experience

NEW APPLICANTS:

1. Provide documentation of providing inpatient or consultative services to a minimum of 24 patients during the past 12 months;
   Or
   Demonstrate successful completion of a clinical fellowship, or research in a clinical setting within the past 12 months.
2. Provide contact information for a physician peer whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

Name _____ Phone: _____

Name of Facility: _____ Fax: _____

Address: _____ Email: _____

REAPPOINTMENT APPLICANTS:

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 clinical competency.

Name _____ Phone: _____

Name of Facility: _____ Fax: _____

Address: _____ Email: _____

☐ CORE II — HIV / AIDS specialist

Privileges

Admit, evaluate, diagnose, consult, and provide care to patients of all ages with AIDS and secondary infections and other related medical conditions. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consulting call services.

Core privileges include procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills.

Basic education and minimal formal training

1. MD, DO, MBBS or MB BCH.
2. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) - or American Osteopathic Association (AOA) - accredited residency in internal medicine;
   And
   Successful completion of a training program in infectious disease.

Or

Current certification or active participation in the examination process leading to subspecialty certification in infectious disease within 5 years by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine;
And
Successful completion of fellowship training;

Or

A minimum of 30 Category I CME credits in HIV/AIDS related medicine.

Required documentation and experience

NEW APPLICANTS:

1. Provide documentation of HIV/AIDS inpatient services provided for at least 10 patients during the past 12 months;
   Or
   Demonstrate successful completion of a clinical fellowship or research in a clinical setting within the past 12 months.
2. Provide contact information for a physician-peer whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

Name _____ Phone: _____

Name of Facility: _____ Fax: _____

Address: _____ Email: _____

REAPPOINTMENT APPLICANTS:

1. Provide documentation showing the number of HIV/AIDS inpatient services performed during the past 24 months;
   Or
   Provide contact information for a qualified physician-peer whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

Name _____	Phone: _____
Name of Facility: _____	Fax: _____
Address: _____	Email: _____

Core Procedure List — Infectious Disease Clinical Privileges

Applicant: Strike though procedures you do not want 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.

Infectious Disease

1. Administration of antimicrobial and biological products via all routes
2. Application and interpretation of diagnostic tests
3. Aspiration of superficial abscess
4. Interpretation of Gram's stain
5. lumbar puncture
6. Management, maintenance, and removal of indwelling venous access catheters
7. perform history and physical exam

HIV/AIDS

1. Coordinate interdisciplinary care by a range of specialists, including all of the medical specialties as well as social services, physical therapy, and psychological support
2. Manage antiretroviral therapy
3. Manage opportunistic infections and diseases
4. monitor patient immunes system
5. Perform history and physical exam
6. Provide expertise in the use of new drugs and possible side effects, including treatment-related lipid disorders and interactions with other drugs
7. Provide patient education, including risk reduction and harm reduction counseling
8. Recommend post exposure prophylaxis protocols and infection control measures
9. Test for and diagnose HIV/AIDS, using state of the art diagnostic techniques, including quantitative viral measures and resistance testing
10. Treat commonly associated co-morbid conditions, including tuberculosis, hepatitis B and C, and syphilis

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.	

Notes:

_____ _____

Signature Date

Regions Hospital
Delineation of Privileges
Moderate Sedation

Privilege
☐ Administer and manage moderate sedation/analgesia, a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone `or accomplished by light tactile stimulation. A patent airway is maintained and spontaneous ventilation is adequate. Cardiovascular function is always maintained.
Basic education and minimal formal training
1. MD, DO, MBBS, MB BCH, DPM, DMD, DDS, 2. Successful completion of an ACGME or AOA or Royal College of Physicians and Surgeons of Canada, approved residency training program. 3. Current ACLS, ATLS or PALS certification.
Required documentation and experience
NEW APPLICANTS: 1. Provide documentation of successful completion of an examination provided by the Regions medical staff services ***Or*** Document experience by providing one of the following: • Evidence of successful completion of a moderate sedation test with passing score from another hospital; • Governing board letter from another hospital indicating the applicant has moderate sedation privileges; • Letter from Medical Staff Office at another hospital indicating specifically that the practitioner has moderate sedation privileges and the date they were granted; • If a recent graduate, attestation of competency from program director. 2. Provide documentation of current ACLS, ATLS or PALS certification. **REAPPOINTMENT APPLICANTS:** 1. Provide documentation of performing moderate sedation for at least ten (10) patients within the past 24 months; ***Or*** Provide documentation from Division/Section Head that attests to ongoing current competence. 2. Provide documentation of current ACLS, ATLS or PALS certification.

TO BE COMPLETED BY APPLICANT: I agree to supply all of the information being requested of me for the privileges I am applying for. I understand my application for privileges will not proceed until the information is received.

_____ _____

Signature Date

TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL: I have reviewed and/or discussed the privileges requested and find them to be commensurate with this applicant's training and experience. I recommend this application proceed.

_____ _____

Signature Date