Regions Hospital
Delineation of Privileges
Neurology

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 neurology
Special privileges in general neurology
Core II – Neurophysiology
Core III – Neuro Critical Care

Core procedure list
Signature page

☐ CORE I — General Neurology

Privilege

Admit, work-up and provide neurological diagnosis and therapy to patients presenting with illnesses of the central and or peripheral nervous system including neuromuscular function and muscle disease.

Basic education and minimal formal training

1. MD, DO, MBBS or MB BCH.
2. Successful completion of an ACGME, AOA or Royal College of Physicians and Surgeons of Canada, approved residency training program in Neurology.
3. Current certification or active participation in the examination process with achievement of certification within 5 years, leading to certification in neurology by the American Board of Psychiatry and Neurology, the American Osteopathic Board of Psychiatry and Neurology, or the Royal College of Physicians and Surgeons of Canada.

Required documentation and experience

NEW APPLICANTS:

1. Provide documentation of inpatient neurological services to at least 24 patients during the past 12 months;
   Or
   Provide contact information for the Director of Neurology at a facility where applicant is currently practicing or a Residency Director if applicant is a new graduate of an accredited Residency program.

Name _____ Phone: _____

Name of Facility: _____ Fax: _____

Address: _____ Email: _____

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 of Neurological services to at least 50 patients 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 _____

Name of Facility: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Special privileges in General Neurology

Privilege

☐ EMG and nerve conduction velocity	☐ Somatosensory evoked responses
☐ Muscle biopsy	☐ Transcranial Doppler
☐ Noninvasive intracranial and extracranial vascular study	☐ Transcutaneous angiography of cerebral vessels
☐ Peripheral nerve biopsy	☐ Visual evoked responses
	☐ Butulinum toxin injection

Basic education and minimal formal training

1. MD, DO, MBBS or MB BCH.
2. Successful completion of an ACGME, AOA, or Royal College of Physicians and Surgeons of Canada approved residency training program in Neurology.
3. Current certification or active participation in the examination process with achievement of certification within 5 years, leading to certification in neurology by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Psychiatry and Neurology.

For noninvasive intra- and extra-cranial vascular study:

- Completion of fellowship in interventional neuro-radiology or neuro-diagnostic imaging

For transcutaneous angiography of cerebral vessels

- Completion of fellowship in interventional neuro-radiology or training in neuro-radiology or diagnostic neuro-imaging

Required documentation and experience

NEW APPLICANTS:

1. Provide documentation of the number of special procedures performed during the past 12 months;
O**r**
Provide contact information for (2) Neurologists trained in the procedure(s) requested whom the credentialing specialist may contact to attest to your clinical competency.

Name _____ Name _____

Name of Facility: _____ Name of Facility: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Email: _____ Email: _____

REAPPOINTMENT APPLICANTS:

1. Provide documentation of the number of procedures 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 — Neurophysiology

Privilege

Select the appropriate modalities to effectively monitor the patient's neurophysiological status within the operating room.

Basic education and minimal formal training

1. MD, DO, MBBS or MB BCH.
2. Successful completion of an ACGME, AOA or Royal College of Physicians and Surgeons of Canada approved residency training program in Neurology.
3. Current certification or active participation in the examination process with achievement of certification within 5 years, leading to certification in neurology by the American Board of Psychiatry and Neurology, the American Osteopathic Board of Psychiatry and Neurology, or the Royal College of Physicians and Surgeons of Canada.
4. Board certified or board eligible by the American Board of Clinical Neurophysiology or equivalent.

Required documentation and experience

NEW APPLICANTS:

1. Provide contact information for two physician peers whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

Name _____ Name _____

Name of Facility: _____ Name of Facility: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Email: _____ Email: _____

REAPPOINTMENT APPLICANTS:

1. Provide contact information for a physician peer whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

Name _____

Name of Facility: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

☐ Core III — Neuro critical care

Privilege

Admit, evaluate, diagnose, and provide treatment or consultative services to critically ill adult patients with multiple organ dysfunctions and in need of critical care for life threatening disorders.

Basic education and minimal formal training

1. MD, DO or MBBS, MB BCH.
2. Completion of an approved residency program in internal medicine, neurology, pediatrics, pulmonary medicine, or surgery with the ACGME, AOA or Royal College of Physicians and Surgeons of Canada.
3. Successful completion of an accredited fellowship in critical care medicine (NOT REQUIRED IF BOARD CERTIFIED IN CRITICAL CARE MEDICINE).
4. Current subspecialty certification or active participation in the examination process -- with achievement of certification within 5 years – in subspecialty certification in critical care medicine by the relevant American Board of Medical Specialties, or the American Osteopathic Board.
5. ACLS, ATLS, PALS or APLS certification.

Required documentation and experience

NEW APPLICANTS:

1. Provide documentation of inpatient care, reflective of the scope of privileges requested, to at least 30 patients in the critical care unit during the past 12 months;

Or

Successful completion of an ACGME- or AOA-accredited residency, clinical fellowship, or research setting within the past 12 months;

And

Provide copy of current ACLS, ATLS, PALS, or APLS certification.

2. Provide contact information for physician peer whom the credentialing specialist may contact to provide an evaluation of your clinical competence.

Name: _____

Name of Facility: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

REAPPOINTMENT APPLICANTS:

1. Provide copy of current ACLS, ATLS, APLS or PALS certification
2. Provide documentation of 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 competence.

Name: _____

Name of Facility: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Core Procedure List — Neurology

To the applicant: Strike though those procedures you do not wish to request.

General Neurology

- Autonomic testing
- Balclofen pump
- Caloric testing
- Interpretation of electroencephalogram (EEG)
- Lumbar puncture
- Performance of history and physical exam
- Tensilon testing

Neurophysiology

- Auditory evoked responses
- Autonomic testing
- Continuous video EEG monitoring or operative monitoring for neurosurgery and orthopedic cases
- EEG interpretation
- EMG and nerve conduction studies
- Epilepsy monitoring
- Muscle biopsy
- Performance of history and physical exam
- Peripheral nerve biopsy
- Polysomnography and assessment of sleep disorders
- Somatosensory-evoked responses
- Visual-evoked response

Critical Care Clinical Privileges

- Airway maintenance intubation, including fiberoptic bronchoscopy and laryngoscopy
- Arterial puncture
- Cardiopulmonary resuscitation
- Calculation of oxygen content, intrapulmonary shunt and alveolar arterial gradients
- Cardiac output determinations by thermodilution and other techniques
- Temporary cardiac pacemaker insertion and application
- Cardioversion
- Echocardiography interpretation
- Electrocardiography interpretation
- Esophagoscopy and gastroscopy
- Evaluation of oliguria
- Extracorporeal membrane oxygenation (ECMO)
- Insertion of central venous and arterial lines
- Insertion of hemodialysis, peritoneal dialysis catheters
- Intracranial pressure monitoring
- Lumbar puncture
- Management of anaphylaxis and acute allergic reactions
- Management of life-threatening disorders in intensive care units, including but not limited to shock, coma, heart failure, trauma, respiratory arrest, drug overdoses, massive bleeding, diabetic acidosis, and kidney failure
- Management of massive transfusions
- Management of the immunosuppressed patient
- Monitoring and assessment of metabolism and nutrition
- Needle and tube thoracostomy
- Paracentesis
- Percutaneous needle aspiration of palpable masses
- Percutaneous tracheostomy/cricothyrotomy tube placement
- Perform history and physical exam
- Pericardiocentesis
- Peritoneal dialysis
- Peritoneal lavage
- Preliminary interpretation of imaging studies
- Thoracentesis
- Tracheostomy
- Transtracheal catheterization
- Image guided techniques as an adjunct to privileged procedures
- Use of reservoir masks, nasal prongs/canulas and nebulizers to deliver supplemental oxygen and inhalants
- Ventilatory management, including experience with various modes and continuous positive airway pressure therapies (BiPAP and CPAP)
- Wound care
- Interpretation of transcranial Doppler monitoring
- Management of thrombolytic therapy
- Management of patients after peripheral and cerebral endovascular procedures
- Management of cerebral perfusion pressure

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