Regions Hospital
Delineation of Privileges
Dermatology

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 staff privileges in dermatology
Special Privileges
  - laser
  - Mohs micrographic surgery
  - dermatopathology

Core procedure list
Signature page
CORE I — General privileges in dermatology

<table>
<thead>
<tr>
<th>Privileges</th>
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<tbody>
<tr>
<td>Admit, 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 non-allergic 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 disease. Assess, stabilize and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills.</td>
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Basic education and minimal formal training

1. MD, DO, MBBS or MB BCH.
2. Successful completion of an approved ACGME, AOA or Royal College of Physicians and Surgeons of Canada accredited dermatology residency program.
3. Current board certification in dermatology -- or active participation in the examination process with achievement of certification within 5 years – by the American Board of Medical Specialties, or the American Osteopathic Board.

Required documentation and experience

NEW APPLICANTS:

1. Successful completion of an ACGME- or AOA-accredited residency within the past 24 months; and
2. Provide contact information for the residency training program director whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

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Or

If more than 2 years beyond completion of residency, provide the names of two physician peers whom the credentialing specialist may contact to provide an evaluation of your clinical competence.

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REAPPOINTMENT APPLICANTS:

1. 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: _________________________________________
**Special privileges in dermatology (check those that apply)**

<table>
<thead>
<tr>
<th>Privilege</th>
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<tbody>
<tr>
<td>Mohs' Micrographic Surgery</td>
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**Basic education and minimal formal training**

1. Same criteria as Core I privileges.
2. Formal training in Mohs’ Micrographic Surgery.

**Required documentation and experience**

**NEW APPLICANTS:**

1. Provide documentation of completion of a Mohs micrographic surgery training program by the director, or equivalent;  
   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: _________________________________________

**REAPPOINTMENT APPLICANTS:**

1. Provide evidence of providing Mohs’ micrographic surgery to patients on an ongoing basis;  
   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 dermatology continued (check those that apply)

<table>
<thead>
<tr>
<th>Privilege</th>
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<tr>
<td>□ Dermatopathology</td>
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**Basic education and minimal formal training**

1. Same criteria as Core I privileges
2. Successful completion of a fellowship in dermatopathology.
3. Current certification in dermatopathology -- or active participation in the examination process, with achievement of certification within 5 years – by the American Board of Dermatology and Pathology.

**Required documentation and experience**

**NEW APPLICANTS:**
1. Provide evidence of successful completion of a dermatopathology fellowship program from the program director
   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: ________________________________

**REAPPOINTMENT APPLICANTS:**
1. Provide documentation of the practice of dermatopathology on an ongoing basis;
   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 — laser

Privileges

Indicate selection/s with an “X.” Practitioner agrees to limit practice to the specific laser chosen.

- Angiodynamics endovenus diode (model venus cure)
- Cardiogenesis Holium Yag (model ns 2000)
- Lumenis Holium Yag (model power suite 100W)
- Lumenis Holium Yag (model: power suite 20W)
- Iridex oculight TX KPP Yag (model 3200-1)
- Sharplan CO2 (model 1041S)
- SSI CO2 40W (model: MD40)

Basic education and minimal formal training

1. Must have Core I privileges.
2. Successful completion of an approved residency in a specialty or subspecialty that included training in laser principles;
   Or
   Completion of an approved CME course of 8-10 hours duration that included training in laser principles and at least 6 hours of observation and hands-on-experience.

Required documentation and experience

NEW APPLICANTS:
1. Provide documentation of the performance of at least five laser procedures in the past 24 months;
   Or
   Provide contact information for a residency or fellowship director whom the credentialing specialist may contact to provide an evaluation of your competency with the laser/s requested.

   Name: ______________________________________________________
   Name of Facility: _____________________________________________
   Address: ____________________________________________________
   Phone: ________________________   Fax: _______________________
   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 competency with the laser/s requested.

   Name: ______________________________________________________
   Name of Facility: _____________________________________________
   Address: ____________________________________________________
   Phone: ________________________   Fax: _______________________
   Email: ______________________________________________________
Core Procedure List — Dermatology

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.

Performance of history and physical exam

Dermatology
1. Performance of history and physical exam
2. Botulinum toxin injection
3. Chemical face peels
4. Collagen injections
5. Cryosurgery
6. Destruction of benign and malignant tumors
7. Electrosurgery
8. Excision of benign and malignant tumors with simple, intermediate and complex repair techniques, including flaps and grafts
9. Intralental injections
10. Potassium hydroxide examination
11. Tzanck smears
12. Patch tests
13. Photomedicine, phototherapy, and topical/systemic pharmacotherapy
14. Sclerotherapy
15. Skin and nail biopsy
16. Soft tissue augmentation

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

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