University of Michigan
Hospitals and
Health Centers

Delineation of Privileges
Department of Internal Medicine / Division of Allergy

Applicant's Name _____

Date *First* *MI* *Last*

Instructions: **Check the box corresponding to the privileges that you are requesting. Applicants requesting privileges should only request those privileges when the minimum criteria has been met.**

Minimum threshold for requesting core privileges in Department / Service

☐ I meet the following mentioned minimum criteria and request that my application be considered for the privileges as outlined below.

LEVEL I

Requested	Recommended	Scope of Practice / Privileges	Minimum Training and Experience
☐	☐	Privileges include admission, work up, diagnosis, and provision of non-surgical treatment including consultation for patients who are admitted or in need of care to treat general medical problems. Physicians with these privileges may act as consultants to others, and may in turn be expected to request consultations when a) diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness; b) unexpected complications arise which are outside the physician level of competence; and c) specialized treatment or procedures are contemplated with which they are not familiar. Included in the core practice of Internal Medicine are the following activities. Abdominal paracentesis Arterial puncture for blood gases Central venous cannulation Electrocardiogram interpretation Fiberoptic flexible sigmoidoscopy Joint aspiration/injection Lumbar puncture Nasogastric tube insertion Thoracentesis Bone marrow biopsy	M.D. or D.O. degree Successful completion of approved residency training program in Internal Medicine and/or Pediatrics. Required previous experience: Active participation in the care of at least 24 general internal medicine and/or pediatric patients during the past 12 months. Minimum certification and Board status: Must be Board Certified Board in Allergy and Clinical Immunology by the American Board of Internal Medicine or the American Board of Pediatrics within 5 years of initial appointment. Under exceptional circumstances, the Division Chief and Department Chair can recommend to the Hospital Executive Board (via the Credentials Committee and ECCA) that the Board requirement be waived.

LEVEL II

Requested	Recommended	Privileges	Minimum Training and Experience
☐	☐	Patch tests Office pulmonary function testing Examination of respiratory secretion cytology Aerobiological sampling and related exposure analysis Tests for physical urticarias	Education beyond general Internal Medicine/Pediatric training: Minimum formal training Two-year Fellowship in Allergy Required previous experience: Active participation in the care of at least 24 patients with illnesses relevant to the practice of Allergy during the past 12 months. Minimum certification and Board status: Board certified in Allergy and Clinical Immunology by the American Board of Internal Medicine or Pediatrics within 5 years of initial appointment. Under exceptional circumstances, the Division Chief and Department Chair can recommend to the Hospital Executive Board (via the Credentials Committee and ECCA) that the Board requirement be waived.
☐	☐	Skin testing for inhalant allergens Skin testing for food allergens Skin testing for drugs and chemicals Skin testing for latex allergy Hymenoptera venom allergy testing Nasal and bronchial challenge testing Testing for sensitivity to penicillin and other drugs Prescribing of allergen immunotherapy	

LEVEL III

Requested	Recommended	Privileges	Additional Education, Training and Experience
☐	☐	Rhinoscopy without biopsy (flexible)	As above with additional documentation (specific courses where technical features are taught or equivalent clinical experience) of training and experience in rhinoscopy. Minimum of five (5) procedures per year to retain privilege.

TO BE COMPLETED BY APPLICANT:

I authorize and release from liability, any hospital, licensing board, certification board, individual or institution who in good faith and without malice, provides necessary information for the verification of my professional credentials for membership to the Medical Staff of The University of Michigan Health System.

Applicant Signature: _____ Date: _____

DEPARTMENT ACTION:

Approval: ☐ As Requested ☐ As modified, explain _____

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

Justification for approval is based on careful review of the applicant's education, postgraduate clinical training, demonstrated clinical proficiency and Board Certification or qualifications to sit for the Boards.

Department Chair: _____ Date _____ Service Chief: _____ Date _____

CREDENTIALS COMMITTEE ACTION:

Approval: ☐ As Requested ☐ Disapproved, explain _____

Credentials Committee Member: _____ Date _____

EXECUTIVE COMMITTEE ON CLINICAL AFFAIRS ACTION:

Approval: ☐ As Requested ☐ Disapproved, explain _____

Executive Committee On Clinical Affairs Member: _____ Date _____