

## Delineation of Privileges Department of Pathology

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.

**Note:** Applicants must attach to this delineation of privileges supporting documentation attesting to his or her experience and / or formal training.

### 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	Granted	Scope of Practice / Privileges	Minimum Training and Experience
<input type="checkbox"/>	<input type="checkbox"/>	<p>Pathology is the medical discipline that utilizes laboratory techniques to solve disease related problems. Pathologists participate in the care of patients by interpreting tissue specimens and laboratory information to help solve diagnostic problems and monitor effects of treatment.</p> <p>Clinical (Laboratory) Pathologist: Responsible for the general clinical laboratories such as clinical chemistry (including toxicology), microbiology, immunology, molecular diagnostics, and cytogenetics. Hematopathology (including flow cytometry), blood banking/transfusion medicine, and coagulation require level II privileges.</p> <p>Anatomic Pathologist: Responsible for the interpretation and diagnosis of cytologic and tissue specimens, including frozen section diagnosis, fine needle aspiration and specialty examinations.</p>	<p>M.D. Required. Training in Pathology, either anatomic (AP), clinical (CP) and/or anatomic/clinical pathology. Five years training and experience in AP, CP or AP/CP desired for staff membership. The candidate should have passed the certification examination by the American Board of Pathology in AP, CP or AP/CP or must be board eligible*.</p> <p>*Exceptions to the requirement for Board Certification, and where indicated, Subspecialty Qualification, will be prospectively stated and requested by the Service Chief.</p>

**LEVEL II**

Requester	Granted	Privileges	Minimum Training and Experience
<input type="checkbox"/>	<input type="checkbox"/>	Hematopathology (including Clinical Flow Cytometry)	M.D. required. AP, AP/CP, or CP boards or eligibility. 5 years training and experience desired for staff membership. Hematopathology subspecialty training and/or equivalent experience. 6 weeks/year on service.
<input type="checkbox"/>	<input type="checkbox"/>	Blood Banking/Transfusion Medicine	M.D. required. AP/CP or CP boards or eligibility. 5 years training and experience desired for staff membership. Blood Bank/Transfusion subspecialty and/or equivalent experience. 6 weeks/year on service.
<input type="checkbox"/>	<input type="checkbox"/>	Coagulation	M.D. required. AP/CP or CP boards, Internal medicine, Pediatrics boards or eligibility. 5 years training and experience desired for staff membership. Thrombosis/Hemostasis subspecialty training (Pathology, Pediatrics or Internal Medicine) and/or equivalent experience. 6 weeks/year on service.
<input type="checkbox"/>	<input type="checkbox"/>	Cytopathology	M.D. required. AP/CP or AP boards or eligibility. 5 years training and experience desired for staff membership. Cytopathology subspecialty and/or equivalent experience. 6 weeks/year on service.
<input type="checkbox"/>	<input type="checkbox"/>	Dermatopathology	M.D. required. AP/CP or AP boards or eligibility. 5 years training and experience desired for staff membership. Dermatopathology subspecialty and/or equivalent experience. 6 weeks/year on service.
<input type="checkbox"/>	<input type="checkbox"/>	Neuropathology	M.D. required. AP/CP or AP boards or eligibility. 5 years training and experience desired for staff membership. Neuropathology subspecialty and/or equivalent experience. 6 weeks/year on service.

**LEVEL II (continued)**

Requested	Granted	Privileges	Minimum Training and Experience
<input type="checkbox"/>	<input type="checkbox"/>	Pediatric Pathology	M.D. required. AP/CP or AP boards or eligibility. 5 years training and experience desired for staff membership. Pediatric Pathology subspecialty and/or equivalent experience. 6 weeks/year on service.
<input type="checkbox"/>	<input type="checkbox"/>	Forensic Pathology	M.D. required. AP/CP or AP boards or eligibility. 5 years training and experience desired for staff membership. Forensic Pathology subspecialty and/or equivalent experience. 6 weeks/year on service.

**LEVEL III**

Requested	Granted	Privileges	Additional Education, Training and Experience
<input type="checkbox"/>	<input type="checkbox"/>	There are no Level III privileges at this time.	
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		



**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 \_\_\_\_\_