University of Michigan Hospitals and Health Centers

Delineation of Privileges
Department of Pediatrics / Division of Pediatric Infectious Diseases

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 of Pediatrics,Division of Infectious Diseases

❑ 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	Minimal Training and Experience
❑	❑	Privileges include being able to admit, work-up, diagnose, and provide treatment or consultative services to patients of all ages ranging from the newborn to young adulthood presenting with signs or symptoms suggestive of an infectious process or immunodeficiency.	M.D. or D.O. Successful completion of any approved residency training program in pediatrics and completed fellowship/3 years experience in clinical/research in infectious diseases. Board eligible or certified in pediatrics. Board eligible or certified in pediatric infectious diseases. Provision of inpatient or consultative services for at least 24 patients during the past 12 months.

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LEVEL II

Requested	Granted	Privileges	Minimal Training and Experience
❑	❑		

LEVEL III

Requested	Granted	Privileges	Additional Education, Training and Experience
❑	❑		
❑	❑		
❑	❑		

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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 applicantís 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 _____