University of Michigan
Hospitals and Health Centers

# Delineation of Privileges
# Department of Pediatrics / Division of Critical Care Medicine

_______________ ***Applicant's Name*** ________________________________________

*Date* *First* *MI* *Last*

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

**<u>Minimum threshold for requesting core privileges in Department / Service</u>**

❑ 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 |
|---|---|---|---|
| ❑ | ❑ | 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.<br><br>Physicians with these privileges may act as consultants to others, and may in turn be expected to request consultation 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. | Basic Education: M.D. or D.O degree.<br><br>Minimum form of training: Successful completion of an approved residency training program in Pediatrics.<br><br>Required previous experience: Active participation in the care of pediatric patients during the past 12 months.<br><br>Minimum certification and Board status: Certification by the American Board of Pediatrics within 5 years of initial appointment.<br><br>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 I (continued)

| Requested | Granted | Scope of Practice / Privileges | Minimum Training and Experience |
|---|---|---|---|
| | | Included in the core practice of Pediatrics are the following activities:<br><br>Privileges include: | Appropriate education and experience are indicated by successful completion of a Pediatric residency training program by the individual's demonstrated competence in the treatment areas or procedures.<br><br>Determination of competence is based on the judgment of the Division Chief who will make use of treatment results and quality measures. |
| ❑ | ❑ | Abdominal Paracentesis | |
| ❑ | ❑ | Arterial puncture for blood gases | |
| ❑ | ❑ | Central venous cannulation | |
| ❑ | ❑ | Electrocardiogram interpretation | |
| ❑ | ❑ | Joint aspiration/injection | |
| ❑ | ❑ | Lumbar puncture | |
| ❑ | ❑ | Nasogastric tube insertion | |
| ❑ | ❑ | Thoracentesis | |

## LEVEL II

| Requested | Granted | Privileges | Minimum Training and Experience |
|---|---|---|---|
| | | Privileges include the ability to admit, work up, diagnose, and treat Pediatric patients with injuries to and diseases of the circulatory, pulmonary, nervous, gastrointestinal, nephrologic, and otolaryngologic systems.<br><br>Physicians with these privileges have the highest level of competence in Pediatric Critical Care Medicine on a par with that considered appropriate for a subspecialist They are qualified to act as consultants from within or from outside the Medical Center whenever needed.<br><br>Included in the practice of Pediatric Critical Care Medicine are the following activities: | Minimum formal training: Fellowship in Pediatric Critical Care Medicine.<br><br>Required previous experience: Active participation in the care of at least 24 patients with illnesses relevant to the practice of Pediatric Critical Care Medicine during the past 12 months.<br><br>Minimum certification and board status: Board certified in Pediatric Critical Care by the American board of Pediatrics within 5 years of initial appointment.<br><br>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<br>requirement be waived. |
| ❑ | ❑ | Bronchoscopy with lavage, brushing, and biopsy | |
| ❑ | ❑ | Cardiopulmonary resuscitation | |
| ❑ | ❑ | Chest tube insertion and management | |
| ❑ | ❑ | Hemodynamic monitoring | |

| | | | |
|---|---|---|---|
| ❑ | ❑ | Management of mechanical ventilation | |

## LEVEL II (continued)

| Requested | Granted | Privileges | Minimum Training and Experience |
|---|---|---|---|
| ❑ | ❑ | Non-invasive cardiovascular monitoring including electrocardiogram | |
| ❑ | ❑ | Placement of arterial, central venous, and pulmonary artery catheters | |
| ❑ | ❑ | Pulmonary function testing | |
| ❑ | ❑ | Thoracentesis | |
| ❑ | ❑ | Tracheal intubation | |
| ❑ | ❑ | Transtracheal catheter placement | |
| ❑ | ❑ | High frequency ventilation | |
| ❑ | ❑ | Intracranial pressure monitoring | |
| ❑ | ❑ | Extracorporeal membrane oxygenation maintenance | |
| ❑ | ❑ | Continuous veno-venous hemofiltration | |

## LEVEL III

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

**SPECIAL PRIVILEGES**

**To APPLY or REAPPLY for the following Special Privileges,
a separate application is required.**

**FLUOROSCOPY for a non-Radiologist/Radiation Oncologist**

**LASER**
**ROBOTIC SURGICAL PLATFORM**
**SEDATION PRIVILEGES for a non-Anesthesiologist**

**PLEASE go to URL: www.med.umich.edu/i/oca for instructions, or contact your Clinical Department Representative.**

**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__________