MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

PEDIATRIC ENDROCRINOLOGY CLINICAL PRIVILEGES

Name: _____

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Service Chief / Department Chair: Check the appropriate box for recommendation on this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

- Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have sufficient space, equipment, staffing, and other resources required to support the privilege.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR PEDIATRIC ENDOCRINOLOGY

Initial Applicants - To be eligible to apply for privileges in pediatric endocrinology, the initial applicant must meet the following criteria:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in pediatrics followed by successful completion of an accredited fellowship in pediatric endocrinology.

AND

Current subspecialty certification or board eligible (with achievement of certification within five years of completion of training) leading to subspecialty certification in pediatric endocrinology, by the American Board of Pediatrics, or certification of special qualifications in pediatric endocrinology by the American Osteopathic Board of Pediatrics or UMHS approved international equivalent.

AND

Required Current Experience: Demonstrated current competence and evidence of inpatient or consultative services to at least **24** patients, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

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CORE PRIVILEGES – PEDIATRIC ENDOCRINOLOGY

Applicant: Requested Initial ☐ **Requested Renewal** ☐

Service Chief/Chair: Recommended ☐ **Not Recommended** ☐

Admit, evaluate, diagnose, consult, and provide treatment to infants, children and adolescents with diseases or disorders resulting from an abnormality in the endocrine glands, including but not limited to diabetes mellitus, growth disorders, early or late pubertal development, birth defects, disorders of sex differentiation, gender dysphoria, bone and mineral homeostasis, and disorders of the thyroid, adrenal and pituitary glands. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine 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 procedure list and such other procedures that are extensions of the same techniques and skills.

Focused Professional Practice Evaluation (FPPE NEW HIRE/NEW PRIVILEGE) guidelines: New physicians will be monitored for an initial five (**5**) patients that are a representative mix of pediatric endocrinology privileges granted. Methods must include direct observation, and may include case review, proctoring, discussions with other medical professionals involved in the care of each patient, and review of patient feedback.

Reappointment (Renewal of Privilege) Requirements - To be eligible to renew privileges in pediatric endocrinology, the re-applicant must meet the following criteria:

Board eligible or board certified

AND

Current demonstrated competence and an adequate volume of experience (**48** patients) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

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CORE PROCEDURE LIST

This list is not intended to be an all-encompassing procedure list. It defines the types of activities/procedures/privileges that the majority of practitioners in this specialty perform at this organization and inherent activities/procedures/privileges requiring similar skill sets and techniques.

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

1. Perform history and physical exam
2. Chronic subcutaneous insulin infusion
3. Interpret hormone assays
4. Interpret laboratory studies, including the effects of non-endocrine disorders
5. Interpretation of normal and abnormal growth curves
6. Perform and interpret hormonal stimulation and suppression tests e.g., growth hormone, gonadotropins, ACTH stimulation and hypoglycemia challenge
7. Preliminary interpretation of radiologic and other imaging studies for diagnosis and treatment of endocrine and metabolic diseases

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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 for which I wish to exercise at Michigan Medicine, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed _____ ***Date*** _____

SERVICE CHIEF / DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges.
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

Service Chief Signature _____ ***Date*** _____

Department Chair Signature _____ ***Date*** _____

FOR MEDICAL STAFF SERVICES DEPARTMENT USE ONLY

Credentials Committee Action ***Date*** _____

Executive Committee on Clinical Affairs Action ***Date*** _____

Governing Board Action ***Date*** _____