MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

PEDIATRIC HEMATOLOGY/ONCOLOGY 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 HEMATOLOGY/MEDICAL ONCOLOGY

Initial Applicants - To be eligible to apply for privileges in pediatric hematology/oncology, 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 hematology/oncology.

AND

Current subspecialty certification or board eligible (with achievement of certification within five years of completion of training) leading to subspecialty certification in pediatric hematology/oncology, by the American Board of Pediatrics or 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 for at least twenty-five (25) patients, reflective of the scope of pediatric hematology/oncology privileges requested, during the past 12 months or successful completion of an ACGME or AOA accredited residency and clinical fellowship within the past 12 months.

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CORE PRIVILEGES – PEDIATRIC HEMATOLOGY/ONCOLOGY

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

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

Admit, evaluate, diagnose, consult and provide treatment to children (including newborn and infants), adolescents and young adults presenting with disorders of the blood and immune system and with cancerous diseases. For rare blood disorders and cancer where the expertise lies with pediatric specialists, privileges include any age patient as a consultative role with a primary adult provider. 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 at least five (5) cases that are a representative mix of core pediatric hematology/oncology privileges granted. Methods may include direct observation, 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 hematology/oncology, the re-applicant must meet the following criteria:

Board certification, board eligibility (with achievement of certification within five years of completion of training), or UMHS approved international equivalent.

AND

Current demonstrated competence and experience with at least fifty (50) pediatric patients, reflective of the scope of core pediatric hematology/oncology privileges, for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

NON-CORE PRIVILEGES (SEE SPECIFIC CRITERIA)

Non-Core Privileges are requested individually in addition to requesting the core. Each individual requesting Non-Core Privileges must meet the specific threshold criteria as applicable to the initial applicant or re-applicant.

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BONE MARROW TRANSPLANTATION

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

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

Includes: High dose chemotherapy with autologous peripheral blood stem cell and/or bone marrow transplantation, allogeneic bone marrow transplantation, stem cell harvest, bone marrow infusion, and cellular therapy infusion. Includes punch biopsy of the skin.

Criteria: Successful completion of an ACGME/AOA-accredited training program in pediatric hematology/ oncology fellowship with BMT clinical experience.

Required Current Experience: Demonstrated current competence and evidence of the performance of at least five (5) BMT procedures in the past 12 months or completion of training in the past 12 months. These procedures must be in the BMT area (harvesting, autologous transplants, or allogeneic transplants) for which privileges are requested.

FPPE NEW HIRE/NEW PRIVILEGE: All new applicants will be proctored for five (5) BMT procedures. 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.

Renewal of Privilege: Demonstrated current competence and evidence of the performance of at least ten (10) procedures reflective of the BMT area requested in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

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SPECIAL INSTITUTIONAL PRIVILEGES (SEPARATE APPLICATION REQUIRED)

A separate application is required to APPLY or REAPPLY for the following Special Privileges:

- **►FLUOROSCOPY**
- **►HYPERBARIC OXYGEN THERAPY**
- **►LASER**
- **►ROBOTIC SURGICAL PLATFORM**
- **►CHEMOTHERAPY (FOR NON-ONCOLOGIST)**
- **►SEDATION PRIVILEGES (FOR A NON-ANESTHESIOLOGIST)**
- **►BATTLEFIELD AURICULAR ACUPUNCTURE**

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

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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. Administration of chemotherapeutic agents, immunotherapeutic agents, and biological response modifiers through all therapeutic routes, including but not limited to:
    a. Intrathecal injection of chemotherapy by lumbar puncture
    b. Intrathecal injection of chemotherapy via CSF reservoir
3. Assessment of tumor imaging by computed tomography, magnetic resonance, PET scanning, and nuclear imaging techniques
4. Bone marrow biopsy or harvest
5. Coagulation assays (standard) performance and interpretation, including: bleeding time, partial thromboplastin time, platelet aggregation, or prothrombin time
6. Diagnostic lumbar puncture with evaluation of cerebrospinal fluid
7. Management and maintenance of indwelling venous access catheters
8. Preparation, staining, and interpretation of peripheral blood smears, performing bone marrow aspirates, and touch preparations as well as interpretation of bone marrow biopsies
9. Serial measurement of tumor masses

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Name: _____

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.

Practitioner Printed Name _____

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. _____	_____

Notes

_____

_____

_____

Service Chief Printed Name _____

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

Department Chair Printed Name _____

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*** _____