University of Michigan Hospitals and Health Centers

# Delineation of Privileges
# Department of Pediatrics / Division of Neonatal-Perinatal 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.**

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

**<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 | Minimal Training and Experience |
|---|---|---|---|
| ☐ | ☐ | Newborn infants with major or complex illnesses, injuries, or conditions that require intensive care, significant diagnostic evaluation, and application of life support technology. Areas of expertise include (but are not necessarily limited to) neonatal resuscitation, venous arterial access, endotracheal intubation, thoracentesis, thoracostomy tube placement, ventilatory support, transport of critically ill infants, treatment with inotropic and vasoactive agents, temperature regulation, nutritional support, continuous monitoring, interpretation of laboratory data, perinatal consultations, social implications of fetal and neonatal disorders, and general principles of care. | M.D. or D.O. degree<br>Successful completion of a core residency program in Pediatrics accredited by the Residency Review Committee.<br>Board certified by the American Board of Pediatrics in Pediatrics.<br>Sub-board certified in Neonatal-Perinatal Medicine within five years of initial appointment. |

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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 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 _____