



**PEDIATRIC NEPHROLOGY 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.

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**QUALIFICATIONS FOR PEDIATRIC NEPHROLOGY**

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**Initial Applicants** - To be eligible to apply for privileges in pediatric nephrology, 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 nephrology.

AND

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

AND

Required Current Experience: Demonstrated current competence and evidence of the care of at least twenty-five (25) patients, reflective of the scope of pediatric nephrology privileges requested, within the last 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 NEPHROLOGY**

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**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 with diseases and disorders or normal and abnormal development and maturation of the kidney and urinary tract, damage to the kidney, evaluation and treatment of renal diseases, fluid and electrolyte abnormalities, hypertension and renal replacement therapy. Includes medical management of renal transplant patients. 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 nephrology 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 nephrology, 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 an experience with at least fifty (50) pediatric nephrology patients, 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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**SPECIAL INSTITUTIONAL PRIVILEGES (SEPARATE APPLICATION REQUIRED)**

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**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](http://www.med.umich.edu/i/oca/mss/pdocs) for instructions, or contact your Clinical Department Representative.**



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**CORE PROCEDURE LIST**

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*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. Acute and chronic hemodialysis
3. Biochemical monitoring and treatment
4. Continuous renal replacement therapy
5. Coordinating end stage renal care
6. Filter-based plasmapheresis
7. Interpretation of urine microscopy
8. Evaluation of renal pathology specimens
9. Evaluation of the renal and urinary tract imaging procedures
10. Interpretation of ambulatory blood pressure monitor
11. Nutritional therapy
12. Percutaneous biopsy of autologous and transplanted kidney
13. Peritoneal dialysis
14. Placement of acute peritoneal dialysis catheter
15. Preoperative evaluation and preparation for transplantation



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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.

**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:

<b>Privilege</b>	<b>Condition/Modification/Explanation</b>
1. _____	_____
2. _____	_____
3. _____	_____

**Notes**  
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\_\_\_\_\_  
\_\_\_\_\_

**Service Chief Printed Name** \_\_\_\_\_

**Service Chief Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Department Chair Printed Name** \_\_\_\_\_

**Department Chair Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**FOR MEDICAL STAFF SERVICES DEPARTMENT USE ONLY**  
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**Credentials Committee Action** \_\_\_\_\_ **Date** \_\_\_\_\_

**Executive Committee on Clinical Affairs Action** \_\_\_\_\_ **Date** \_\_\_\_\_

**Governing Board Action** \_\_\_\_\_ **Date** \_\_\_\_\_