



Medicine - Dermatology FHHM
Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges.
2. **Uncheck** any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign/Date form and Submit with required documentation.
5. 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 doubts related to qualification of requested privileges.

Note:

Privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.

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.

Required Qualifications

Education/Training	Must have successfully completed an ACGME/AOA-accredited residency in Dermatology
Certification	The applicant physician must possess current board certification by the specialty board most commonly applicable to his or her specialty, or become board certified as such within six years of completing his or her residency program or receiving medical staff membership or clinical privileges.
Clinical Experience (Initial)	The successful applicant for initial appointment must provide documentation of provision of outpatient or consultative care, reflective of the scope of privileges requested, to at least 12 patients in the past 12 months or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship or research in a clinical setting within the past 12 months.
Clinical Experience (Reappointment)	To be eligible to renew core privileges in Dermatology, the applicant must demonstrate competence and an adequate volume of experience 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. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Primary Privileges Dermatology

Description: Core Privileges include admit (if requested), evaluate, diagnose, treat, and provide consultation to patients with benign and malignant disorders of the integumentary system (epidermis, dermis, subcutaneous tissue, hair, nails, mouth, external genitalia, and cutaneous glands) as well as sexually transmitted diseases. Assess, stabilize, and determine disposition of patients. 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.

Request	<p align="center">Request all privileges listed below. <i>Uncheck any privileges that you do not want to request</i></p>	Dept Chair Rec
	Admit and manage patients in non-critical care and unmonitored settings	
	Perform History and Physical Examinations	
	Consultation privileges in Dermatology	
	Botulinum toxin injection	
	Chemical face peels	
	Collagen injections	
	Cryosurgery	
	Dermabrasion	
	Diagnosis and treatment of skin cancers, moles, and other tumors of the skin	
	Electrosurgery	
	Excision of benign and malignant tumors with simple, intermediate and complex repair techniques including flaps and grafts	
	Interpretation of specially prepared tissue sections, cellular scrapings, and smears of skin lesions by means of routine and special (electron and fluorescent) microscopes	
	Management of contact dermatitis, allergic and nonallergic skin disorders, skin manifestations of systemic (including internal malignancy), and infectious diseases	
	Management of cosmetic disorders of the skin such as hair loss and scars and the skin changes associated with aging	
	Patch tests	
	Scalp surgery	
	Sclerotherapy	
	Skin and nail biopsy	
	Soft tissue augmentation	

Laser

Description: The below special privileges are not routinely part of the post-graduate training program. Additional proof of training and/or experience may be necessary to request the privilege and is noted within the privilege block. If documentation is required, please submit all required elements with your application/reapplication.

Qualifications

Education/Training Successful completion of an approved residency in a specialty or subspecialty that included training in laser principles or provide documentation appropriate to the specific laser to be utilized.
AND
 Practitioner agrees to limit practice to only the specific laser types for which they have been provided documentation of training and experience.

Request	<p align="center">Request all privileges listed below. <i>Uncheck any privileges that you do not want to request</i></p>	Dept Chair Rec
	Laser	

Acknowledgment of Applicant

I hereby request the clinical privileges as indicated. I understand that such privileges include rendering of all associated diagnostic and supportive measures necessary in performance of the privileges I have requested, and in treating associated diseases with adequate consultation when indicated.

I recognize that in emergency situations where immediate life-saving action is necessary, any member of the medical staff is authorized to perform such life-saving treatment as may be required.

I further understand that any and all privileges granted me shall be commensurate with my documented training and demonstrated competence, judgment and capabilities. The Credentials and Executive Committees of the medical staff and the Board of Trustees of the hospital reserve the right to grant or limit my privileges in accord with my continuing performance in rendering patient care.

 Practitioner's Signature _____
Date

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

	Recommend all requested privileges
	Do not recommend any of the requested privileges
	Recommend privileges with the following conditions/modifications/deletions (listed below)

Privilege	Condition/Modification/Deletion/Explanation

Additional Comments

Signature of Department Chair/Designee

Date