



**Wound Care KHHM**  
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**

<b>Education/Training</b>	Successful completion of an ACGME/AOA/CPME accredited post-graduate training program.
<b>Certification</b>	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.
<b>Clinical Experience (Initial)</b>	Applicant must demonstrate that provision of care to at least 12 inpatients or outpatients during the past 12 months.
<b>Clinical Experience (Reappointment)</b>	Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes.
<b>Special Procedures available to MD/DO Only</b>	Physicians supervising hyperbaric oxygen therapy must be credentialed by the hospital in which the therapy is being performed. The Undersea and Hyperbaric Medical Society (UHMS) recommends the medical staff meet the following minimum education elements: successful completion of a 40- hour UHMS-approved hyperbaric medicine introductory course. <p style="text-align: center;"><b>AND</b></p> As in other medical specialties, the physician should seek and gain continuing experience and knowledge through diligent practice, appropriate consultation, and ongoing medical education. A minimum of 16 hours of continuing HBOT education every 2 years after initial credentialing.

**Note**

If any privileges are covered by an exclusive contractual agreement, physicians who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training and experience.

**Primary Privileges Wound Care**

**Description:** Core Privileges include: provide services to patients with wound and skin disorders on a non-emergent basis.

Request	<p align="center"><b>Request all privileges listed below.</b>  <i>Uncheck any privileges that you do not want to request</i></p>	Dept Chair Rec
	<b>PHYSICIANS MD/DO Only</b>	
	Application of Skin Substitute	
	Complicated Wound Management	
	Emergency Myringotomy	
	Emergency Pneumothorax Decompression	
	Incision and Drainage of Abscesses	
	Inpatient Consultation for Wound Care Management	
	Local and Regional Anesthesia (MD/DO)	
	Minor Surgical Debridement of Wounds	
	Simple Laceration Repair	
	Transcutaneous Oximetry Interpretation	
	Wound Biopsy	
	<b>CORE PRIVILEGES IN WOUND CARE PODIATRIST (DPM)</b> (Core Privileges include: provide services to patients with soft tissue wound and skin disorders of the leg and foot, on a non-emergent basis.)	
	Application of Skin Substitute (Foot & Ankle Only)	
	Complicated Wound Management (Foot & Ankle Only)	
	Incision & Drainage of Abscesses (Foot & Ankle Only)	
	Inpatient Consultation for Wound Care Management (Foot & Ankle Only)	
	Local & Regional Anesthesia (DPM - Foot & Ankle Only)	
	Minor Surgical Debridement of Wounds (Foot & Ankle Only)	
	Simple Laceration Repair (Foot & Ankle Only)	
	Transcutaneous Oximetry Interpretation (Foot & Ankle Only)	
	Wound Biopsy (Foot & Ankle Only)	

## Hyperbaric Management - MD/DO Only

### Qualifications

<b>Education/Training</b>	Documentation of successful completion of a 40-hour UHMS-approved hyperbaric medicine introductory course.
<b>Clinical Experience (Reappointment)</b>	Must demonstrate competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested

Request	<i><b>Request all privileges listed below.</b></i> <i>Uncheck any privileges that you do not want to request</i>	Dept Chair Rec
	Provide hyperbaric management without consultation	
	<b>Management of HBOT Complications</b>	
	Barotrauma	
	Oxygen Toxicity	

## 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