_____HOSPITAL

ESTABLISHING NEW PRIVILEGE/NEW PROCEDURE CRITERIA

INFORMATION REQUIRED	INFORMATION SUBMITTED
HOSPITAL ASSESSMENT **Hospital CEO/Designee Signature Date** **Hospital CFO/Designee Signature Date** **Hospital CNO/Designee Signature Date**	**Hospital CEO, CNO and CFO or designees have reviewed the request to perform this procedure or to provide this service, the suggested criteria and agree that:** ❒ **There is a community need** ❒ **Hospital has sufficient space** ❒ **Hospital has sufficient resource personnel appropriately trained** ❒ **Financial/reimbursement issues have been clarified** ❒ **Hospital can accommodate this new procedure – treatment-service** ❒ **Issues/problems have been identified concerning the following:_____** _____ _____ _____ _____
SPECIALTIES INVOLVED:	
PROCEDURE/CONDITION/PRIVILEGE/SERVICE REQUESTED:	
GENERAL REQUIREMENTS	**1. Must be a member in good standing of the _____Medical Staff;** **2. Staff Category Requirement:_____** **3. Current licensure in the state of:_____ with no sanctions;** **4. Current State and/or Federal DEA certificate with no sanctions;** **5. Concurrent privileges with no disciplinary action in the specialty(ies) of:_____** **6. Appropriate professional liability insurance as defined by the professional liability insurance carrier suggestion and the medical staff** _____
REQUIRED EDUCATION AND TRAINING ☐ **MD/DO** ☐**DDS/DMD** ☐**DPM**	**1. Successful completion of an accredited medical/professional school;** **2. Successful completion of an**

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INFORMATION REQUIRED	INFORMATION SUBMITTED
☐APN ☐PA ☐DC ☐Ph.D. ☐ Other:_____	☐ACGME ☐AOA ☐ADA ☐APA accredited residency/fellowship in:_____ 3. Other:_____
SPECIALTY BOARD STATUS: ❒ American Board of Medical Specialties (ABMS) ❒ American Osteopathic Association (AOA) ❒ American Board of Podiatric Surgery (ABPS) ❒ American Board of Podiatric Orthopedics & Primary Podiatric Medicine (ABPOPPM) ❒ American Dental Association (ADA) ☐ National Commission on Certification of Physician Assistants (NCCPA) ❒ Council on Certification of Nurse Anesthetists (CCNA) ❒ American Midwifery Certification Board (AMCB) ❒ Other:_____	1) Board certified or actively involved in the examination process to be achieved within _____ years. (If board certification is not achieved within the specified time frame, consequences will be:_____ _____) 2) Other:_____
PEER REFERENCES AND/OR EVALUATIONS	❒ Letter from chairman of the relevant clinical department or residency training program director attesting to the applicant's competence in this privilege/procedure/service. ❒ Written confirmation of _____cases/procedures within the past _____months/years. (Documentation should indicate satisfactory performance with acceptable outcomes) ❒ Peer recommendations from at least _____ persons who have had extensive experience and knowledge of the applicant and can attest to the applicant's health status and current clinical competence for the privilege(s) being requested ❒ Other:_____ _____
MONITORING/PROCTORING:	❒ Concurrent observation of _____cases/procedures with documentation from proctor on appropriate form. ☐ Length of time:_____ ☐ Less than _____% complication rate ❒ Retrospective review of medical records of _____cases/procedures ❒ FPPE shall include: _____ _____ ❒ Other:_____

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INFORMATION REQUIRED	INFORMATION SUBMITTED
CME REQUIREMENTS	❒ **Initial Request** ❒ **Documentation confirming _____ hours of Category I CME activity during the previous _____months/years on the specific procedure/service,** ❒ **Attendance at specific CME program(s)** ❒ **Manufacturer's Training Course/Certificate** **Other Specifications:_____** _____ _____
REAPPOINTMENT/RE-PRIVILEGING REQUIREMENTS	❒ **1)Confirmation of successful completion of _____procedures/services with acceptable outcomes within the past 24 months as determined by medical staff peer review activities;** ❒ **2)Confirmation of _____ patients treated with a specific condition/service required with acceptable outcomes within the past 24 months as determined by medical staff peer review activities;** ❒ **Documentation from an accredited healthcare facility of #1 or #2 above for practitioners who have not met the numeric requirements at this institution;** ❒ **CME activity during the previous two years** ❒ **Peer recommendations** ❒ **Other:_____** _____
APPROVAL:	**New Procedure/New Service Committee Chair Date** **Division Chief Date** **Department Chair Date** _____ **Second Department Chair Date** **Credentials Committee Chair Date** **MEC Chair Date** **Board of Trustees Chair Date**

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INFORMATION REQUIRED	INFORMATION SUBMITTED
This form Reviewed and Approved: **Credentials Committee:** **MEC:** **Board of Trustees** **Revisions:**	_____