



Privileges in Hematology/Oncology

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of **Core Privileges**.
2. **Uncheck** any privileges you do not want to request in this group.
3. Individually check off any **Special Privileges** you want to request.
4. Sign form electronically and **submit with all required documentation**.

Required Qualifications

**Initial Core Criteria
Education/Training**

Successful completion of an ACGME or AOA accredited Residency training program in Pediatrics or foreign equivalent training

AND

Successful completion of an approved Fellowship program in Pediatric Hematology/Oncology or foreign equivalent training.

AND

Current certification or active participation in the examination process leading to sub-board certification in Pediatric Hematology/Oncology by the American Board of Pediatrics or foreign equivalent training/board.

FPPE

FPPE CRITERIA LISTED BELOW. FPPE WILL BE ASSIGNED BY THE SERVICE CHIEF DURING THE APPROVAL PROCESS

Core Privileges

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
	Privileges to admit, evaluate, diagnose, consult, perform history and physical, and provide treatment to patients presenting with malignant tumors or illnesses and disorders of the blood, blood-forming tissue, or diseases of hemostasis	
	Diagnostic lumbar puncture	
	Bone marrow aspiration and biopsy	

Qualifications

Clinical Experience (Reappointment) Minimum 30 Core Pediatric Hematology/Oncology inpatients or outpatients required during the past 2 years (Be prepared to provide a list of cases performed at facilities other than LPCH if requested)

FPPE

Core

Special Privileges

Description: Must also meet Required Qualifications for Core Privileges

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
	Order, prescribe and sign systemic chemotherapy or immunotherapy, including systemic immunosuppressive therapy with drugs, antibody products, and cellular immunotherapy, for malignant or nonmalignant diseases in children and adolescents. [Initial Criteria - Must perform 20 within 2-year period and provide documentation log. Renewal Criteria - Minimum 10 cases required in the past two years.]	
	Administration of intrathecal chemotherapy for malignant diseases in children and adolescents [Initial Criteria - . Must perform 5 within 2-year period and provide documentation log. Renewal Criteria - Minimum 5 cases required in the past two years.]	
	SHC Hematologist/Oncologists - Hematology/Oncology care limited to that required to care for adult patients in the multidisciplinary hemophilia clinic. [Initial Criteria - Meeting Core Privilege criteria for pediatric hematology/oncology training or equivalency is not required. Current active privileges in Hematology or Oncology at SHC. Renewal Criteria - Minimum management of 20 hematology or oncology patients required at SHC in the past two years.]	

FPPE

Order, prescribe and sign systemic chemotherapy or immunotherapy for malignant or nonmalignant diseases in children and adolescents
 Administration of intrathecal chemotherapy
 SHC Hematologist/Oncologists (managed at SHC) (Chart Reviews)

Acknowledgment of Applicant

I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at Stanford Children's Health. I also acknowledge that my professional malpractice insurance extends to all privilege I have requested.

I acknowledge I have met the minimum number of cases required as identified for privileges.

I understand that 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.

By clicking on the "Submit" button below, I have electronically signed, dated and submitted this privilege request _____ Date

Service Chief Recommendation - Privileges

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

Privilege	Condition/Modification/Deletion/Explanation

Service Chief Recommendation - FPPE Requirements

Service Chief/Designee - By clicking on the 'Submit' button below, I have electronically signed, dated and approved this privilege request

Date