



Privileges in Hospitalist Medicine Service Privileges

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**.
5. To have **Administration of Sedation** privileges you must complete LPCH Sedation Privilege form (contact your medical staff coordinator for the form)

Required Qualifications

Education/Training

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

AND

Current certification or active participation in the examination process leading to certification in Pediatric Hospital Medicine or Pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics foreign equivalent training/board.

AND

Current certification in PALS from the American Heart Association.

FPPE

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

Core Privileges**Qualifications**

Renewal Criteria Minimum 100 cases required during the past 2 years

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 exam, and provide treatment to patients	
	Incision and Drainage of Abscesses	
	Repair of Wounds	
	Oxygen Delivery and Airway Management (BMV, Intubation)	
	Vascular Access	
	Treatment of major or complicated illness	
	Lumbar Puncture	
	Foreign body removal	
	Suturing laceration	
	Skin abscess incision and drainage	
	Blood Drawing	
	Frenotomy	
	Care of well newborns in Newborn Nursery	

FPPE

Core

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