Privileges in Stem Cell Transplant

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 Immunology or foreign equivalent training. At least one year of clinical training/experience in Stem Cell Transplantation is required after the fellowship training in Allergy and immunology. **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 in Allergy and Immunology by the American Board of Allergy and Immunology; or current certification or active participation in the examination process leading to sub-board certification in Pediatric Allergy and Immunology or Conjoint Pediatric and Internal Medicine Allergy and Immunology by the American Osteopathic 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

Qualifications

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

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	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	☐
☐	Management and care of indwelling venous access catheters	☐
☐	Diagnostic lumbar puncture	☐
☐	Bone marrow aspiration and biopsy	☐

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☐ Core

Special Privileges

Description: Must also meet Required Qualifications for Core Privileges

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Dept Chair Rec ☐
☐	Bone marrow harvest [Initial Criteria - Must have performed 2 within 2-year period and provide documentation log. Renewal Criteria - Minimum 1 case required in the past two years.]	☐
☐	Infusion or the follow up after infusion of hematopoietic stem and progenitor cell products (bone marrow, peripheral blood stem cells, umbilical cord stem cells, purified stem or progenitor cells) for patients undergoing hematopoietic stem cell transplantation. [Initial Criteria - Must perform 3 within 2-year period and provide documentation log. Renewal Criteria - Minimum 3 cases required in the past two years.]	☐
☐	Administration and/or follow up of immune modulatory therapy, including systemic immunosuppressive therapy with drugs, antibody products, and/or cellular immunotherapy, for treatment or prevention of graft-versus-host disease (GVHD). [Initial Criteria - Must perform 5 within 2-year period and provide documentation log. Renewal Criteria - Minimum 5 cases required in the past two years.]	☐
☐	Administration and/or follow up of systemic chemotherapy 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 and/or follow up of 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.]	☐

FPPE

- ☐ Administration of immune modulatory therapy, including systemic immunosuppressive therapy with drugs, antibody products, and/or cellular immunotherapy, for treatment or prevention of graft-versus-host disease (GVHD)
- ☐ Administration of systemic chemotherapy, immunotherapy or cellular therapy and/or care of patients receiving one of these therapies
- ☐ Infusion of hematopoietic stem and progenitor cell products
- ☐ Bone marrow harvest

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

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

Submit