

Adolescent Medicine

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 for Initial Core Criteria	<p>Successful completion of an ACGME or AOA accredited Residency training program in either Pediatrics, Internal Medicine or Family Medicine or foreign equivalent training</p> <p>AND</p> <p>Successful completion of an approved Fellowship program in Adolescent Medicine or foreign equivalent training or documentation of at least three years' experience with adolescent patients</p> <p>AND</p> <p>Current certification or active participation in the examination process leading to certification in Adolescent Medicine by either the American Board of Pediatrics, Internal Medicine or Family Medicine or foreign equivalent training/board. For non-trained applicants in Adolescent Medicine or foreign equivalent training, current certification or active participation in the examination process leading to certification in either Pediatrics, Internal Medicine or Family Medicine or foreign equivalent boards</p> <p>AND</p> <p>Documentation or attestation of the management of problems for at least 10 inpatients or outpatients as the attending physician (or senior resident) during the past 2 years</p>
FPPE	<p>FPPE CRITERIA LISTED BELOW. FPPE WILL BE ASSIGNED BY THE SERVICE CHIEF DURING THE APPROVAL PROCESS</p>

Core Privileges

Request <input type="checkbox"/>	<i>Request all privileges listed below.</i> <i>Uncheck any privileges that you do not want to request.</i>	Service Chief <input type="checkbox"/>
	CORE Privileges	
<input type="checkbox"/>	Privileges to admit, evaluate, diagnose, consult, perform history and physical exam, and provide treatment to patients presenting with adolescent illness or conditions	<input type="checkbox"/>
<input type="checkbox"/>	Pelvic exam	<input type="checkbox"/>
<input type="checkbox"/>	Assessment/management of eating disorders with or without medical instability	<input type="checkbox"/>
<input type="checkbox"/>	Management of disorders associated with substance abuse	<input type="checkbox"/>
<input type="checkbox"/>	Management of reproductive health issues of males and females including contraception and menstrual disorders	<input type="checkbox"/>
<input type="checkbox"/>	Treatment of sexually transmitted infections	<input type="checkbox"/>

Qualifications

Renewal Criteria Management of at least 30 adolescent medicine 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 <input type="checkbox"/>	<i>Request all privileges listed below.</i> <i>Uncheck any privileges that you do not want to request.</i>	Service Chief <input type="checkbox"/>
<input type="checkbox"/>	Treatment of patients in outpatient clinics at Lucile Packard Children's Hospital [Criteria - Teaching appointment required]	<input type="checkbox"/>

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
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