Providence Hospital
of North Houston

Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_____ _____
Print Name Date

Privilege Request Form – Hematology/Oncology

SECTION I – GENERAL REQUIREMENTS HEMATOLOGY/ONCOLOGY

Requested Staff Category

_____ Active _____ Courtesy _____ Consulting _____ Affiliate

Basic Education: MD or DO

INITIAL APPOINTMENT

Minimal formal training and experience:

- Successful completion of an approved residency training program in Internal Medicine followed by a Hematology / Oncology fellowship training program or its equivalent as approved by the ACGME or AOA.
- The number of cases performed in the last 12 months for each procedure requested along with the documentation of proficiency must be sufficient to validate competence. An applicant who has just completed a residency shall provide his/her residency log. Additional documentation and monitoring may be required at the discretion of the Medical Director or the Chief of Staff. Some procedures may require additional documentation of training and experience which is acceptable to the Medical Director such as Proctoring Reports, Operative Reports and Discharge Summaries for other institutions, written communication of documents from the Chairperson of the designee of an approved academic training program, approved continuing medical education course, or clinical department from another institution attesting to completion of a specified course of training, and/or the number of the specified successful procedures performed, and/or the applicants known ability to perform a specific procedure for which the applicant has previously been formally trained to carry out in an approved program.
- Member in good standing of an accredited acute care hospital and/or ambulatory surgery center, with the same or similar unrestricted privileges.
- Certification by the American Board of Internal Medicine
- Interview by the Medical Director and/or Chief of Staff when requested.

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REAPPOINTMENT MAINTENANCE OF PRIVILEGE

- Demonstrated evidence of clinical activity from relevant professional practice evaluation during the past 24 months without significant quality variations, OR
- Peer recommendations when performance data is insufficient at the time of reappraisal; and
- Ongoing maintenance of continuing medical education as it pertains to scope of license and specialty.

SECTION II – PRIVILEGES REQUESTED

CORE PRIVILEGES	REQUESTED	GRANTED	DENIED
Evaluate, diagnose, treat, and provide consultative services to patients presenting with malignant tumors or with illnesses and disorders of the blood and blood-forming tissues.			

CORE PROCEDURE	# PROCEDURES IN LAST 12 MONTHS	REQUESTED	GRANTED	GRANTED W/CONDITIONS	DENIED
Perform History and Physical Examination					
Bone marrow biopsy (aspiration with / without biopsy)					
Chemotherapy of malignant disorders					
Other:					

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I have been approved for these procedures at the following hospitals/ambulatory surgery centers:

SECTION III - ACKNOWNLEDGE OF PRACTITIONER:

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at the Hospital. I hereby attest that the references, reports, records and information are available that verify my qualifications and competency to practice as requested.

I understand that:

1. In exercising any clinical privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

2. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.

3. The use of any other new, untried, or unproven procedure/treatment modality/instrumentation maybe performed or used, only after the regular credentialing process has been completed and the privilege to perform or use said procedure/treatment modality/instrumentation has been granted to the individual practitioner

_____ _____
SIGNATURE OF PHYSICIAN DATE

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SECTION IV – RECOMMENDATIONS AND APPROVALS

Recommendation of the Medical Director:

I reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

_____ Approval of all requested privileges

_____ Approval of the following privileges with conditions: _____
_____
_____

_____ Denial of the following privileges: _____
_____

_____ _____
Medical Director **Date**

Recommendation of the Medical Executive committee:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

_____ Approval of all requested privileges

_____ Approval of the following privileges with conditions: _____
_____

_____ Denial of the following privileges: _____
_____

_____ _____
Chief of Staff **Date**

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Decision of the Governing Board:

The Governing Board has reviewed the above recommendations regarding the requested clinical privileges and supporting documentation for the above named applicant and has:

_____ Granted all requested privileges

_____ Granted the following privileges with conditions: _____

_____

_____ Denied the following privileges: _____

_____

_____ _____
Chairman of the Board **Date**