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

_____ _____
Print Name Date

Privilege Request Form – Intraoperative Neuromonitoring Technician

SECTION I – GENERAL REQUIREMENTS

Basic Education: Neuromonitoring training documented by an MD/DO.

INITIAL APPOINTMENT

Minimal Formal Training:

- Documentation of training in Neuromonitoring by an MD or DO.

Exercise of Clinical Privileges:

- May only exercise only those clinical privileges granted by the hospital and assigned by the supervising physician.
- Neuromonitoring Technicians shall be documented and identified on the OR record as an IOM

REAPPOINTMENT MAINTENANCE OF PRIVILEGE

- Demonstrated evidence of clinical activity from relevant professional practice evaluation during the past 24 months without significant quality variations, OR
- Satisfactory Annual reviews of performance from the sponsoring physician; and
- Ongoing maintenance of continuing medical education as it pertains to scope of license and specialty.

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SECTION II – PRIVILEGES REQUESTED

Basic Privileges:

By requesting these privileges, the supervising physician is attesting that he/she has knowledge of the education, training, ability and competence of the Neuromonitoring Technician. The physician is also attesting that granting these clinical privileges is consistent with current medical practice and will not adversely affect patient safety and that he/she shall be legally responsible and accountable for all of the clinical activities performed by the Neuromonitoring Technician, including ensuring that the Neuromonitoring Technician performs only those clinical privileges that have been approved and granted.

All clinical privileges shall be performed under the direct supervision of the supervising physician.

SECTION III - ACKNOWLEDGE OF PRACTITIONER:

Procedure	Requested	Granted	Denied
Intraoperative Monitoring			
Dermatomal Evoked Potentials			
Somatosensory Evoked Potentials			
Brainstem Auditory Evoked Responses			
EMG (i.e. Facial Nerve Monitoring for Brain Tumor)			
EEG			
Motor Evoked Potentials			
Nerve Conductions			
Visual Evoked Potentials			
Triggered EMC			
Transcutaneous MEP			
Sleep Monitoring			
Other (specify)			

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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.

SUPERVISING PHYSICIAN (PRINTED NAME): _____

PHONE # OF SUPERVISING PHYSICIAN: _____

_____ _____
SIGNATURE OF APPLICANT **DATE**

_____ _____
SIGNATURE OF SUPERVISING PHYSICIAN **DATE**

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SECTION IV – RECOMMENDATIONS AND APPROVALS

Recommendation of the Medical Director:

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:
_____

_____ _____
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:
_____

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_____ _____
Print Name Date

_____ _____
Chief of Staff **Date**

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**