Providence Hospital
of North Houston

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

_____ _____
Print Name Date

Privilege Request Form – Physical Medicine & Rehabilitation

SECTION I – GENERAL REQUIREMENTS PHYSICAL MEDICINE & REHABILITATION

Requested Staff Category

_____ Active _____ Courtesy _____ Consulting

Basic Education: MD or DO

INITIAL APPOINTMENT

Minimal formal training and experience:

- Successful completion of an accredited post-graduate training program in Physical Medicine & Rehabilitation 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 of 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.
- Evidence of Board Eligible or Board Certified by the American Board Physical Medicine & Rehabilitation
- 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

Privileges	Requested	Granted	Denied
Core privileges include: Admit, evaluate, diagnose, treat, and provide consultative services to patients presenting with physical impairments and/or disabilities involving neuromuscular, neurologic, cardiovascular or musculoskeletal disorders; patients with functional limitations; patients with spinal cord trauma and diseases including management of bladder and bowel dysfunction; pressure ulcer prevention and treatment and tissue disorders such as burns.			
Core privileges relating to traumatic brain injury include: Physical examination of pain/weakness/numbness syndromes (neuromuscular and/or musculoskeletal) with a diagnostic plan and/or prescription for treatment that may include the use of physical agents and/or other interventions; and evaluation, prescription, and supervision of medical and comprehensive rehabilitation goals and treatment plans.			

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Core Privileges – Wound Care include: Admit, evaluate, diagnose, treat and provide consultative services to patients presenting with Stage I through Stage IV wounds.			
Perform History and Physical Examination			
Core Procedures			
Electrodiagnostic medicine			
Medical and rehabilitative pain management			
Non-surgical spine medicine			
Motor point blocks			
Diagnostic and therapeutic nerve blocks			
Nerve conduction testing			
Joint manipulation/mobilization			
Perform therapeutic and diagnostic injection techniques			
Skin biopsy			
Incision and drainage of abscesses			
Treatment of uncomplicated burns/wounds			
Suture of simple lacerations			
Excision biopsy of skin or subcutaneous tumor			
Major or minor debridement not requiring general anesthesia			
Application and changing of vacuum assisted wound care devices			
Preparation of wound bed and application of skin substitute			
Treatment of necrotizing soft tissue infections			
Treatment of compromised skin grafts and flaps			

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SECTION III - ACKNOWLEDGE 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 APPLICANT **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:
_____

_____ _____
Chief of Staff **Date**

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_____ _____
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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**