Hospital Logo

Hospital Name

Hospital Address

**Application for Clinical Privileges – Medical Oncology/Hematology**

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| --- |
| Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff Category: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effective from \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Request all privileges desired by checking the applicable requested box.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Request | Not Requested |  | Granted | Not Granted |
|  |  | Evaluate, diagnose, provide consultation and medical manage and treat medical oncology/hematology patients. Privileges include medical management of general medical conditions which are encountered in the course of caring or the medical oncology/hematology patient |  |  |
|  |  | Admit patients to the appropriate level of care |  |  |
|  |  | **Procedures: Remove those procedures not within the capabilities and capacities of Hospital** |  |  |
|  |  | Select, initiate and administer chemotherapeutic agents for the treatment of cancer via all therapeutic routes |  |  |
|  |  | Consultative assessment of tumor imaging by CT, MR, PET scanning and nuclear imaging techniques |  |  |
|  |  | Serial measurement of tumor mass |  |  |
|  |  | Supervision of apheresis procedures |  |  |
|  |  | Bone marrow aspiration and biopsy |  |  |
|  |  | Lumbar puncture |  |  |
|  |  | Therapeutic thoracentesis and paracentesis |  |  |
|  |  | Joint aspiration and injection |  |  |
|  |  | Skin biopsy |  |  |
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|  |  |  |  |  |
|  |  | Other Privileges Desired (Not Listed Above) |  |  |
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**Signature of Applicant:**

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I am entitled to perform and that I wish to exercise at (Insert Name of Hospital).

I also understand that by making this request I am bound by the applicable Medical Staff Bylaws and/or policies of (Insert Name of Hospital). I also attest that my professional liability insurance covers the privileges I have requested.

I understand that it is my responsibility to provide (Insert Name of Hospital) with documentation of my education, training, current experience and information regarding the number of services and procedures I have performed in order to assist the Medical Staff in the determination of competency or continued competency.

I affirm that I will obtain a consultation with a qualified medical staff member when it is in the best interest of the patient and/or when my expertise does not meet the clinical needs of the patient.

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 and related documents.

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**Signature of Applicant Date**

**Medical Staff/Credentials Committee Recommendations – Privileges**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s): Please check the applicable box(es)

|  |  |
| --- | --- |
|  | Recommend all requested privileges |
|  | Do not recommend any of the requested privileges |
|  | Recommend privileges with the following conditions/modifications/deletions (listed below) |

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| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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**Medical Staff/Credentials Committee Date**

**Board of Directors Determination**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following determination(s): Please check the applicable box(es).

|  |  |
| --- | --- |
|  | Approve all requested privileges |
|  | Approve none of the requested privileges |
|  | Approve the following privileges with the following conditions/modifications/deletions (listed below) |

|  |  |
| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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Board of Directors Date

Hospital Name

Form Approved By:

Medical Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date

Board of Directors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date