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## Delineation of Privileges in Family Practice Ambulatory Care Primary Care Practitioners (Physicians and Mid-Level Practitioners)

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**CATEGORY I CORE PRIVILEGES:** Practitioner requesting these privileges must be certified or eligible for certification by the appropriate professional organization. Each member must be able to demonstrate ability and competence in the requested privilege.

By checking the "Requested box to the right, the practitioner is hereby requesting the associated privilege.	Requested	Not Requested	Not Recommended	Provisional	Recommended
1. Outpatient Adult Medical Care: general management, diagnosis, and treatment					
2. Outpatient Pediatric Medical Care: general management, diagnosis, and treatment					

**CATEGORY II PRIVILEGES:** Practitioner requesting these privileges must meet the requirements for Category I and have documentation of appropriate training and demonstrate continued proficiency.

By checking the "Requested box to the right, the practitioner is hereby requesting the associated privilege.	Requested	Not Requested	Not Recommended	Provisional	Recommended
1. Circumcision of newborn					
2. Colposcopy and biopsy					
3. Cervix cryosurgery					
4. EKG interpretation					
5. Endometrial biopsy					
6. IUD insertion & removal					
7. Norplant removal					
8. Joint aspiration					
9. Injection of joint, tendon, bursa					
10. Ingrown Nail Excision/Avulsion					
11. Laceration repair					
12. Incision & drainage of abscess					
13. Biopsy skin and subcutaneous					
14. Sebaceous cyst treatment or excision					
15. Venereal warts treatment					
16. Foreign body removal: ear, nose					
17. Cryotherapy for wart/skin lesions					
18. Electrodesiccation/hyfreaction of skin lesions					

- \* Applicant attests that clinical training provided adequate instruction and experience for requested privileges.
- \* Any restriction on clinical privileges granted is waived in an emergency situation.
- \* Clinical privileges expire and must be renewed every two years.

**Signatures of applicant and Chief Medical Officer affirm the ability of applicant to perform the mental and physical tasks necessary for the scope of practice requested.**

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Chief Medical Officer: \_\_\_\_\_ Date: \_\_\_\_\_

Signature & Title of Officer, Board of Directors: \_\_\_\_\_ Date: \_\_\_\_\_

