UNIVERSITY HOSPITALS AND HEALTH SYSTEM
2500 North State Street, Jackson MS 39216

ACUPUNCTURE CLINICAL PRIVILEGES

Name: _____

- ☐ Initial Appointment
- ☐ Reappointment

All new applicants must meet the following requirements as approved by the governing body effective: 4/3/2013.

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Department Chair: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

- Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff and other support required to provide the services defined in this document. Site-specific services may be defined in hospital and/or department policy.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional governance (MS Bylaws, Rules and Regulations) organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR ACUPUNCTURE

To be eligible to apply for core privileges in acupuncture, the initial applicant must meet the following criteria:

Current certification by the American Board of Medical Specialties and current certification by the American Academy of Medical Acupuncture.

OR

Successful completion of an ACGME- or AOA-accredited residency training program; AND completion of 300 hours of graduate training in Medical Acupuncture at AMA Category I certified programs or by consultation with, or endorsement by, the American Academy of Medical Acupuncture; AND active participation in the examination process leading to certification by the American Board of Medical Specialties and American Academy of Medical Acupuncture with achievement of certification within 5 years of completion of formal training.

Required Previous Experience: Applicants for initial appointment must be able to present evidence of a minimum of 20 accredited hours over the past 2-year period of continuing education in medical acupuncture and demonstrate performance of a sufficient volume of acupuncture techniques within the past 24 months.

Reappointment Requirements: To be eligible to renew core privileges in acupuncture, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and sufficient volume of experience with acceptable results, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges. Medical Staff members whose board certificates in a primary specialty and in medical acupuncture bear an expiration date shall successfully complete recertification no later than three (3) years following such

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Name: _____

date. For members whose certifying board requires maintenance of certification in lieu of renewal, maintenance of certification requirements must be met, with a lapse in continuous maintenance of no greater than three (3) years.

CORE PRIVILEGES

ACUPUNCTURE CORE PRIVILEGES

- **Requested** Includes the insertion of acupuncture needles into designated anatomical points as a treatment for pain for adolescent and adult patients. Includes the use of acupuncture to promote health and treat neurological, organic, or functional disorders by the stimulation of specific points on the surface of the body by the insertion of sterilized, single-use disposable needles, including electrical, thermal, mechanical, or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture meridians and to induce acupuncture anesthesia or analgesia. Includes trigger point injections. Includes ordering respiratory. Includes ordering rehab services. Includes perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods.

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Name: _____

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at University Hospital and Health System, University of Mississippi Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. 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 or related documents.

Signed _____ ***Date*** _____

DIVISION CHIEF'S RECOMMENDATION (AS APPLICABLE)

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

☐ Recommend all requested privileges.
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

Division Chief Signature _____ ***Date*** _____

ACUPUNCTURE CLINICAL PRIVILEGES

Name: _____

DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with the following conditions/modifications:
- ☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

Department Chair Signature_____ ***Date***_____

Reviewed:

Revised:
5/5/10, 9/17/2010, 10/5/2011, 12/16/2011, 4/3/2013