UNIVERSITY HOSPITAL AND HEALTH SYSTEM
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 North State Street, Jackson MS 39216

SLEEP MEDICINE 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 SLEEP MEDICINE

To be eligible to apply for core privileges in sleep medicine, the initial applicant must meet the one of the following criteria:

Current subspecialty certification or certificate of added qualification in sleep medicine by the American Board of Family Medicine, American Board of Psychiatry and Neurology, American Board of Pediatrics, American Board of Otolaryngology, American Board of Internal Medicine, American Osteopathic Board of Family Physicians, American Osteopathic Board of Internal Medicine, American Osteopathic Board of Neurology and Psychiatry, or the American Osteopathic Board of Ophthalmology and Otolaryngology-Head and Neck Surgery

OR

Current certification by the American Board of Sleep Medicine (acceptable for applicants who became certified prior to 2007)

OR

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in a primary specialty followed by successful completion of an accredited fellowship in sleep medicine and active participation in the examination process with achievement of certification within 5 years of completion of formal training leading to subspecialty certification in sleep medicine by the American Board of Family Medicine, American Board of Psychiatry and Neurology, American Board of Pediatrics, American Board of

SLEEP MEDICINE CLINICAL PRIVILEGES

Otolaryngology, American Board of Internal Medicine, American Osteopathic Board of Family Physicians, American Osteopathic Board of Internal Medicine, American Osteopathic Board of Neurology and Psychiatry, or the American Osteopathic Board of Ophthalmology and Otolaryngology-Head and Neck Surgery.

Required Previous Experience: Applicants for initial appointment who are in the board examination process must demonstrate that they satisfy practice experience and training requirements for either the training pathway or clinical experience pathway (if applicable) as required by the ABMS or AOA boards outlined in the criteria above.

Applicants who have achieved their board certification in sleep medicine must demonstrate provision of care, reflective of the scope of privileges requested, for a sufficient volume of patients to include polysomnograms and sleep latency tests in the past 24 months.

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

Current demonstrated competence and a sufficient volume of experience, with acceptable results, reflective of the scope of privileges requested, 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 sleep medicine certificates bear an expiration date shall successfully complete recertification no later than three (3) years following such 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. 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

SLEEP MEDICINE CORE PRIVILEGES

☐ **Requested** Evaluate, diagnose, provide consultation and treat patients of all ages, presenting with conditions or disorders of sleep, e.g., sleep-disordered breathing, circadian rhythm disorders, insomnia, parasomnias, narcolepsy, restless legs syndrome. May provide care to patients in the intensive care setting in conformance with unit policies. The core privileges in this specialty include the procedures on the attached procedure list.

SLEEP MEDICINE CLINICAL PRIVILEGES

Name: _____

CORE PROCEDURE LIST

To the applicant: If you wish to exclude any procedures, please strike through those procedures which you do not wish to request, initial, and date.

- Perform history and physical exam
- Perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods
- Interpretation of polysomnography including the following channels: EKG, EEG, EOG, EMG, Airflow, O_2 saturation, end title pCO_2, leg movements, thoracic and abdominal movement, and CPAP/BiPAP titration studies
- Interpretation of multiple sleep latency testing (MSLT)
- Interpretation of maintenance of wakefulness testing (MWT)
- Interpretation of sleep log
- Behavioral treatment of insomnia
- Order respiratory services
- Order rehab services

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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***_____

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DEPARTMENT CHAIR'S RECOMMENDATION

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

_____

_____

_____

Department Chair Signature_____ ***Date***_____

FOR MEDICAL STAFF OFFICE USE ONLY

Credentials Committee Action ***Date***_____

Executive Committee Action ***Date***_____

Board Action ***Date***_____

Reviewed:

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