

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

ADOLESCENT MEDICINE CLINICAL PRIVILEGES

Name: _____

Page 1

- Initial Appointment
 Reappointment

All new applicants must meet the following requirements as approved by the governing body effective: 06/03/15

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 ADOLESCENT MEDICINE

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

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in family medicine, pediatrics or internal medicine followed by successful completion of a fellowship in adolescent medicine.

AND

Current certification by the American Board of Pediatrics, the American Board of Internal Medicine, the American Board of Family Medicine, the American Osteopathic Board of Pediatrics or active participation in the examination process with achievement of certification within 5 years leading to certification by the American Board of Pediatrics, the American Board of Internal Medicine, the American Board of Family Medicine, or the American Osteopathic Board of Pediatrics.

Required Previous Experience: Applicants for initial appointment must be able to demonstrate sufficient volume of provision of clinical ambulatory or inpatient services, reflective of the scope of privileges requested, during the past 24 months or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

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Name: _____

Page 2

Reappointment Requirements: To be eligible to renew core privileges in adolescent 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 board certificates in pediatrics, internal medicine, or family medicine 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

ADOLESCENT MEDICINE CORE PRIVILEGES

- Requested** Admit, evaluate, diagnose, consult and provide care to patients from the age of puberty to early adulthood, with problems of chronic handicaps, disorders of the endocrine system and metabolism, eating disorders, infectious disease, mental illnesses of adolescence including psychopharmacology and psychophysiologic disorders, organ-specific conditions frequently encountered during teenage years, pubertal maturation and its disorders, reproductive disorders, sexual health problems and sexually transmitted diseases, substance abuse other complex or severe illnesses or problems of adolescents with immediate or serious threat to life. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list.

CHECK HERE TO REQUEST PEDIATRIC CLINICAL PRIVILEGES FORM

- Requested**

ADOLESCENT MEDICINE CLINICAL PRIVILEGES

Name: _____

Page 3

SPECIAL NON-CORE PRIVILEGES (SEE SPECIFIC CRITERIA)

If desired, Non-Core Privileges are requested individually in addition to requesting the Core. Each individual requesting Non-Core Privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence.

ETONOGESTREL IMPLANT PLACEMENT AND REMOVAL

Requested

Criteria: Successful completion of an accredited fellowship in adolescent medicine that included training in etonogestrel implant placement and removal OR as for adolescent medicine plus attendance and successful completion of a hands-on training program of at least three (3) hours in duration in the placement and removal of etonogestrel implants.

Required Previous Experience: Applicants for initial appointment must have demonstrated successful performance of a sufficient volume of etonogestrel implant placement and removal, reflective of the scope of privileges requested, in the past 24 months; or demonstrate successful completion of an ACGME accredited fellowship program in adolescent medicine which included training in etonogestrel implant placement and removal within the past 12 months; or demonstrate successful completion of a hands-on training program in the past 12 months.

Maintenance of Privilege: Demonstrated current competence and evidence of the performance of a sufficient volume of etonogestrel implant placement and removal in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

IUD INSERTION AND REMOVAL

Requested

Criteria: Successful completion of an accredited fellowship in adolescent medicine that included training in IUD insertion and removal OR as for adolescent medicine plus attendance and successful completion of a hands-on training program of at least three (3) hours in duration in the insertion and removal of IUDs.

Required Previous Experience: Applicants for initial appointment must have demonstrated successful performance of a sufficient volume of IUD insertions and removals in the past 24 months (may include volume from training) or must demonstrate successful completion of a hands-on training program in the past 12 months. In addition, initial applicants shall be proctored by a board certified physician currently holding the privilege for insertion and removal of IUDs for at least the first three (3) insertions and/or removals.

Maintenance of Privilege: Demonstrated current competence and evidence of the performance of a sufficient volume of IUD insertion and removal in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

ADOLESCENT MEDICINE CLINICAL PRIVILEGES

Name: _____

Page 4

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.

- Order respiratory services
- Order rehab services
- Perform history and physical exam
- Perform routine medical procedures (Venipuncture, skin biopsy, bladder catheterization, fluid and electrolyte management, foreign body removal from nose or ear, manage and maintain indwelling venous access catheter, administer medications and special diets through all therapeutic routes, basic cardiopulmonary resuscitation, superficial burns, evaluation of oliguria, I & D abscess, interpretation of antibiotic levels and sensitivities, interpretation of EKG (for therapeutic purposes), lumbar puncture, arterial puncture and blood sampling, management of anaphylaxis and acute allergic reactions, management of the immunosuppressed patient, monitoring and assessment of metabolism and nutrition, pharmacokinetics, use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry)
- 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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Page 5

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** _____

ADOLESCENT MEDICINE CLINICAL PRIVILEGES

Name: _____

Page 6

CREDENTIALS COMMITTEE REPRESENTATIVE'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

Credentials Representative's Signature _____ **Date** _____

ADOLESCENT MEDICINE CLINICAL PRIVILEGES

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Page 7

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** _____

Reviewed:

Revised:
2/3/2010, 6/2/2010, 12/01/2010, 12/16/2011, 2/1/2012, 4/3/2013, 4/28/2015, 6/3/2015