

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

**PEDIATRIC HEMATOLOGY/ONCOLOGY CLINICAL PRIVILEGES**

Name: \_\_\_\_\_

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- 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 PEDIATRIC HEMATOLOGY/ONCOLOGY**

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**To be eligible to apply for core privileges in Pediatric Hematology/Oncology, the initial applicant must meet the following criteria:**

Current subspecialty certification in pediatric hematology-oncology by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics.

OR

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AO) accredited residency in pediatrics followed by successful completion of an accredited fellowship in pediatric hematology-oncology and active participation in the examination process with achievement of certification in 5 years of completion of formal training leading to subspecialty certification in pediatric hematology-oncology by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics.

**Required Previous Experience:** Applicants for initial appointment must demonstrate provision of inpatient or consultative services, reflective of the scope of privileges requested, for a sufficient volume of pediatric patients 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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**Reappointment Requirements:** To be eligible to renew core privileges in pediatric hematology/oncology, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and a sufficient volume of experience (pediatric patients) 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 pediatric hematology-oncology 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.

**CORE PRIVILEGES**

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**PEDIATRIC HEMATOLOGY/ONCOLOGY CORE PRIVILEGES**

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- Requested** Admit, evaluate, diagnose, consult and provide treatment to children and adolescents, and adults with special needs (or requiring special care consistent with disease process) presenting with diseases and disorders of the blood and immune system and provide treatment or consultative services to children and adolescents with cancerous diseases. May provide care to patients in the intensive care setting in conformance with unit policies. 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.

**SPECIAL NON-CORE PRIVILEGES (SEE SPECIFIC CRITERIA)**

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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.

**ADMINISTRATION OF SEDATION AND ANALGESIA**

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- Requested** See Hospital Policy for Procedural Sedation by Non-Anesthesiologists for additional information.
- **Section One--INITIAL REQUESTS ONLY:**
    - Completion of residency or fellowship in anesthesiology, emergency medicine or critical care **-OR-**
    - Completion of residency or fellowship within the past year in a clinical subspecialty that provides training in procedural sedation training **-OR-**
    - Demonstration of prior clinical privileges to perform procedural sedation along with a good-faith estimate of at least 20 such sedations performed during the previous year (the estimate should include information about each type of procedure where sedation was administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:

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\_\_\_\_\_  
\_\_\_\_\_  
**-OR-**

- Successful completion (within six months of application for privileges) of a UMHC-approved procedural sedation training and examination course that includes practical training and examination under simulation conditions.

- **Section Two--INITIAL AND RE-PRIVILEGING REQUESTS:**

- Successful completion of the UMHC web based Procedural Sedation Course/Exam initially and at least once every two years **-AND-**  
Provision of a good-faith estimate of the number of instances of each type of procedure where sedation is administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**-AND-**

- ACLS, PALS and/or NRP, as appropriate to the patient population. **(Current)**

**-OR-**

- Maintenance of board certification or eligibility in anesthesiology, emergency medicine, pediatric emergency medicine, cardiovascular disease, advanced heart failure and transplant cardiology, clinical cardiac electrophysiology, interventional cardiology, pediatric cardiology, critical care medicine, surgical critical care, neurocritical care or pediatric critical care, as well as active clinical practice in the provision of procedural sedation.

**Section Three--PRIVILEGES FOR DEEP SEDATION:**

- I am requesting privileges to administer/manage deep sedation as part of these procedural sedation privileges.

**Deep Sedation/Anesthetic Agents used:** \_\_\_\_\_

\_\_\_\_\_  
APPLICABLE TO REQUESTS FOR DEEP SEDATION ONLY:

**I have reviewed and approve the above requested privileges based on the provider's critical care, emergency medicine or anesthesia training and/or background.**

\_\_\_\_\_  
Signature of Anesthesiology Chair

\_\_\_\_\_  
Date

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**BONE MARROW TRANSPLANTATION**

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- Requested** High dose chemotherapy with autologous peripheral blood stem cell and/or bone marrow transplantation
- Requested** Allogeneic bone marrow transplantation
- Requested** Stem cell harvest

**Criteria:** Successful completion of an ACGME/AOA-accredited training program in medical oncology, hematology, or immunology followed by completion of a BMT fellowship program or a minimum of one year of clinical experience in a Foundation for the Accreditation of Cellular Therapy (FACT) accredited BMT program that included autologous and allogeneic transplantation. **Required previous experience:** Demonstrated current competence and evidence of the performance of a sufficient volume of BMT procedures in the past 24 months. These procedures must be in the BMT area (harvesting, autologous transplants, or allogeneic transplants) for which privileges are requested. **Maintenance of Privilege:** Demonstrated current competence and evidence of the performance of a sufficient volume of procedures reflective of the BMT area requested in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

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**CORE PROCEDURE LIST**

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**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.*

- Administration of chemotherapeutic agents and biological response modifiers through all therapeutic routes
- Apheresis
- Assessment of tumor imaging by computed tomography, magnetic resonance, PET scanning, and nuclear imaging techniques
- Complete blood count, including platelets and white cell differential, by means of automated or manual techniques
- Diagnostic lumbar puncture and interpretation of cerebrospinal fluid cytospins
- Lymph node aspiration
- Management and maintenance of indwelling venous access catheters
- Order respiratory services
- Order rehab services
- Partial exchange transfusions
- 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
- Phlebotomy
- Preparation, staining, and interpretation of blood smears, performing bone marrow aspirates and biopsies, and touch preparations as well as interpretation of bone marrow aspirates
- Serial measurement of tumor masses

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**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:

<b>Privilege</b>	<b>Condition/Modification/Explanation</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**Notes**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Division Chief Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**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

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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:

<b>Privilege</b>	<b>Condition/Modification/Explanation</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**Notes**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Credentials Representative's 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:

<b>Privilege</b>	<b>Condition/Modification/Explanation</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**Notes**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Department Chair Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Reviewed:

Revised:  
2/3/2010, 6/2/2010, 9/7/2011, 12/16/2011, 2/1/2012, 4/3/2013