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

PEDIATRIC NEUROLOGY CLINICAL PRIVILEGES

Name: _____

☐ Initial Appointment
☐ Reappointment

All new applicants must meet the following requirements as approved by the governing body effective: 04/02/2014.

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 NEUROLOGY

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

Current subspecialty certification in child/adolescent neurology by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

OR

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in child/adolescent neurology and active participation in the examination process with achievement of certification within 5 years of completion of formal training leading to subspecialty certification in child/adolescent neurology by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

Required Previous Experience: Applicants for initial appointment must provide documentation of the provision of neurological services, reflective of the scope of privileges requested, to a sufficient volume of 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 child neurology, 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 child/adolescent neurology 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

PEDIATRIC NEUROLOGY CORE PRIVILEGES

☐ **Requested** Admit, evaluate, diagnose, treat, and provide consultation to patients of all ages with all types of disease or disorders or impaired function, both acquired and congenital, of the brain, spinal cord, peripheral nerves, muscles, and autonomic nervous system, including their coverings, blood vessels, and other effector tissue, such as muscle. 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)

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.

PERFORMANCE AND INTERPRETATION OF ELECTROMYOGRAPHY EVALUATION (EMG) AND NERVE CONDUCTION STUDIES

☐ **Requested**

Criteria: 1) Successful completion of an ACGME or AOA accredited post graduate training program in physical medicine and rehabilitation OR neurology OR an accredited fellowship program in clinical neurophysiology OR an ACGME accredited electrodiagnostic medicine fellowship, AND 2) achievement of subspecialty certification in clinical neurophysiology by the American Board of Psychiatry and Neurology with EMG emphasis OR the American Board of Electrodiagnostic Medicine (ABEM) within 5 years. ***Required Previous Experience***: Demonstrated current competence and evidence of the performance and interpretation of a sufficient volume of EMGs in the past 12 months. ***Maintenance of Privilege***: Demonstrated current competence and evidence of the performance and interpretation of a sufficient volume of EMGs in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

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CLINICAL NEUROPHYSIOLOGY DIAGNOSTIC STUDIES

Criteria: Successful completion of a postgraduate training program in which clinical neurophysiology was included, AND current subspecialty certification or achievement of subspecialty certification in clinical neurophysiology by the American Board of Psychiatry and Neurology within 5 years of completion of formal training. ***Required Previous Experience***: Demonstrated current competence and evidence of the performance of a sufficient volume of clinical neurophysiology diagnostic studies reflective of privileges requested in the past 12 months or completion of training in the past 24 months. ***Maintenance of Privilege***: Demonstrated current competence and evidence of the performance of a sufficient volume of clinical neurophysiology diagnostic studies reflective of privileges requested in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ **Requested** Autonomic testing, somatosensory evoked responses, auditory evoked responses, and visual evoked responses

☐ **Requested** Continuous video EEG monitoring or operative monitoring for neurosurgery and orthopedic cases

PERFORMANCE OF SKELETAL MUSCLE BIOPSY

Criteria: Successful completion of an ACGME or AOA accredited post graduate training that included training in performance of skeletal muscle biopsy. Applicants must have performed a sufficient volume of skeletal muscle biopsies in training. ***Required Previous Experience***: Demonstrated current competence and evidence of the performance of a sufficient volume of skeletal muscle biopsies in the past 12 months. ***Maintenance of Privilege***: Demonstrated current competence and evidence of the performance of a sufficient volume of skeletal muscle biopsies in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ **Requested**

PERFORMANCE OF SURAL NERVE BIOPSY

Criteria: Successful completion of an ACGME or AOA accredited post graduate training program that included training in sural nerve biopsy. Applicants must have performed a sufficient volume of sural nerve biopsies in training. ***Required Previous Experience***: Demonstrated current competence and evidence of the performance of at least the first 5 sural nerve biopsies under the supervision of a physician who currently has been granted the procedure (or by an appropriate proctor approved by the department chair). ***Maintenance of Privilege***: Demonstrated current competence and evidence of the performance of a sufficient volume of skeletal muscle biopsies in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ **Requested**

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INTERPRETATION OF HISTOLOGICAL, HISTOCHEMICAL, AND BIOCHEMICAL ABNORMALITIES OF MUSCLE AND NERVE TISSUE

Criteria: Successful completion of an ACGME or AOA accredited post graduate training program that included training in interpretation of histological, histochemical, and biochemical abnormalities of muscle and nerve tissue. Applicants must have done a sufficient volume of interpretations in training. ***Required Previous Experience***: Demonstrated current competence and the performance of the first 10 procedures at UHHS under the supervision of a neurologist or pathologist who has been granted the privilege (or an appropriate proctor approved by the department chair). ***Maintenance of Privilege***: Demonstrated current competence and evidence of the performance of a sufficient volume of interpretations in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ **Requested**

NEUROPSYCHOLOGICAL EXAMINATION

Criteria: Successful completion of an ACGME or AOA postgraduate training program that included training in neuropsychological examinations. ***Required Previous Experience***: Demonstrated current competence and evidence of the performance of a sufficient volume of neuropsychological examinations in the past 12 months. ***Maintenance of Privilege***: Demonstrated current competence and evidence of the performance of a sufficient volume of neuropsychological examinations in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ **Requested**

NEURO OPHTHALMOLOGIC DIAGNOSTIC TESTING

Criteria: Successful completion of an ACGME or AOA postgraduate training program that included training in neuro ophthalmologic diagnostic testing. ***Required Previous Experience***: Demonstrated current competence and evidence of the performance of a sufficient volume of neuro ophthalmologic diagnostic tests in the past 12 months. ***Maintenance of Privilege***: Demonstrated current competence and evidence of the performance of a sufficient volume of neuro ophthalmologic diagnostic tests in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ **Requested**

ADMINISTRATION OF SEDATION AND ANALGESIA

☐ **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:

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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 or critical care specialties, 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 and I attest that this practitioner is competent to perform the privileges requested.

_____ _____
Signature of Anesthesiology Chair Date

PRIVILEGES FOR ADULT NEUROLOGY

☐ **Requested** Check here to request an Adult Neurology privilege form.

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PRIVILEGES FOR PEDIATRICS

☐ **Requested** Check here to request a General Pediatrics privilege form.

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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.

Pediatric Neurology

- 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
- Interpretation of EEG
- Baclofen pump management
- Vagal nerve stimulation
- Botulinum toxin injection
- Order respiratory services
- Order rehab services
- Telehealth

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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:

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

Notes

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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:

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

Notes

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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:

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

Notes

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Department Chair Signature_____ ***Date***_____

Reviewed:

Revised:
2/3/2010, 6/2/2010, 12/16/2011, 1/4/2012, 2/1/2012, 11/07/2012, 4/3/2013, 04/02/2014