First Choice
COMMUNITY HEALTHCARE

APPLICATION FOR CLINICAL PRIVILEGES - MEDICAL

☒ **Initial Privileges** ☒ **Renewal of Privileges** ☒ **Expansion of Privileges**
Select only the expanded privileges you are requesting. Do not include privileges that have already been approved.

Print Applicant Name (Last, First, MI) | Title | Date of Hire

The granting, reviewing, and changing of clinical privileges for the staff of FIRST CHOICE COMMUNITY HEALTHCARE (FCCH) shall be in accordance with FCCH policy. Assignment of such clinical privileges is based upon education, clinical training, experience, demonstrated current competence, documented results of patient-care, and other quality review and monitoring deemed appropriate.

The principal of "documented competency" will prevail. Primary care medicine is a dynamic and comprehensive field. Adult medicine, OB-GYN, pediatric care,and mental health care are integral components of a Community Health Center's continuity of care. As a result, privileges in these areas are identified to pertain to primary care specialties of pediatrics, internal medicine, family practice, obstetrics/gynecology and community oriented behavioral health services.

The privileges for FCCH will be granted in the following classes:

CORE PRIVILEGES: LEVEL ONE (GENERAL)

This class includes privileges for uncomplicated, basic procedures and clinical application of cognitive skills. Providers applying for privileges in this class will be graduates of approved medical/osteopathic/Podiatric Medicine schools or licensed schools for physician assistants or nurse practitioners. Providers will be properly licensed, and have demonstrated skills in appropriate general medicine practice.

CORE PRIVILEGES: LEVEL TWO

Privileges in this class include Level One privileges, as well as privileges for those procedures and cognitive skills involving more serious medical problems and which normally are taught in residency programs. This may include procedures and clinical application of cognitive skills appropriate to the care in perinatal, and behavioral health services or advanced pediatric, cardiology, gynecological or adult medicine. Providers requesting privileges in this class will have met the criteria in Level One, and will also have either completed training in a residency program and/or will be Board Certified, or will have documented experience, demonstrated abilities and current competence for the requested specific privileges.

IT SHOULD BE NOTED THAT, EVEN THOUGH A PROVIDER IS ASSIGNED ONE OF THE TWO CLASSES, HE OR SHE MAY ALSO ELECT TO APPLY FOR INDIVIDUAL PRIVILEGES THAT MAY BE CONSIDERED TO BE IN A HIGHER CLASS.

Applicant's Initials_____

FIRST CHOICE COMMUNITY HEALTHCARE
DELINEATION OF MEDICAL PRIVILEGES FORM

Print Applicant Name (Last, First, MI)

Applicant: *Please select the "Requested" box for the set of privileges you are reqeusting. If you wish to exclude any procedure, please strike through the procedure you do not wish to request, then initial and date. If you are only requesting an expanded privilege and/or the privilege is requested under supervision please check the appropriate box next to the requested privilege then initial and date.*

☐ Requested
LEVEL ONE (GENERAL) CORE PRIVILEGES

	Expanded	***Supervised***	***Initial / Date***
1. Management of Routine Pediatric Care	☐	☐	
2. Management of Routine Adult Care	☐	☐	
3. Management of Routine Prenatal Care	☐	☐	
4. Management of Routine Adolescent Care	☐	☐	
5. Management of Routine Gynecologic Care	☐	☐	
6. Management of Routine Geriatric Care	☐	☐	
7. Cardiopulmonary resuscitation (BLS)	☐	☐	
8. Debridement, skin or subcutaneous, tissue	☐	☐	
9. Dressing & Debridement, burn	☐	☐	
10. EKG Interpretation	☐	☐	
11. Foreign body removal, ear	☐	☐	
12. Foreign body removal, eye (not corneal)	☐	☐	
13. Foreign body removal, nose	☐	☐	
14. I&D, Bartholin Cyst	☐	☐	
15. I&D, Paronychia,	☐	☐	
16. I&D, uncomplicate soft tissue abscess	☐	☐	
17. Initial evaluation of musculoskeletal problems	☐	☐	
18. Incisional removal of foreign body	☐	☐	
19. IUD removal	☐	☐	
20. Needle aspiration of subcutaneous lesion	☐	☐	
21. PFT (pulmonary function test) interpretation	☐	☐	
22. Suturing of simple lacerations (one layer)	☐	☐	
23. Treatment of planter warts	☐	☐	
24. Treatment uncomplicated dermatological conditions	☐	☐	
25. Use of local anesthics for wound repair	☐	☐	
26. Waived Laboratory Testing	☐	☐	

Applicant's Initials_____

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☐ **Requested** **LEVEL TWO CORE PRIVILEGES**			
	Expanded	***Supervised***	***Initial / Date***
1. Biopsy, skin	☐	☐	
2. Cervical Biopsy	☐	☐	
3. Cervical Cryotherapy	☐	☐	
4. Colposcopy	☐	☐	
5. ECHO Hepatitis C	☐	☐	
6. ECHO Rheumatology	☐	☐	
7. Endometrial Biopsy	☐	☐	
8. Hyfercation and Fulguration	☐	☐	
9. I&D complicated abscess	☐	☐	
10. I&D perirectal abscess	☐	☐	
11. Ingrown toenail excision	☐	☐	
12. Insertion & removal of long-acting reversible contraceptives ***Documentation of training mandatory**	☐	☐	
13. IUD insertion	☐	☐	
14. Joint aspiration and injectionof major joints (i.e. shoulder, hip, knee)	☐	☐	
15. Joint Asprirations	☐	☐	
16. Lacerations, infected	☐	☐	
17. Outpatient subcutaneous heparin/LMW heparin management	☐	☐	
18. Prenatal care with moderate risk, including • gestastional diabetes • history of genital herpes • mild chronic hypertension • mild pre-eclampsia	☐	☐	
19. Procedures involving destruction of nail bed	☐	☐	
20. Suturing of simple 2 layer lacerations	☐	☐	
21. Treatment of Closed Dislocations and uncomplicated fractures	☐	☐	
22. Trigger point injection	☐	☐	

Applicant's Initials_____

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DELINEATION OF MEDICAL PRIVILEGES FORM

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☐ **Requested**

BEHAVIORAL HEALTH CORE PRIVILEGES

	Expanded	***Supervised***	***Initial / Date***
1. Screening for behavioral health needs	☐	☐	
2. SBIRT intervention	☐	☐	
3. Psychotrophic medication management	☐	☐	
4. Behavioral health counseling	☐	☐	
5. Buprenorphine for Addiction Management	☐	☐	
6. Psychotherapy (psychiatrist or psychologist only)	☐	☐	

☐ **Requested**

OTHER PROCEDURES OR SERVICES

	Expanded	***Supervised***	***Initial / Date***
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Acknowledgement

By signing below, I hereby request the privileges identifed. Furthermore, I certify that I am qualified to provide the privileges I have requested and have received and possess the necessary and required professional licensure, education, training, ongoing experience, competence and judgement to perform the above procedures and/or categorical levels of care which I have indicated.

Applicant's Signature

Date

I have reviewed the requested clinical privileges for the above-named provider and recommed the requested privileges.

Clinical Supervisor Signature

Date

Applicant's Initials_____

FIRST CHOICE COMMUNITY HEALTHCARE
DELINEATION OF MEDICAL PRIVILEGES FORM

Print Applicant Name (Last, First, MI)

PRIVILEGE APPROVAL – MEDICAL DIRECTOR

Date of Hire:

Position: ☐ MD ☐ DO ☐ CNP/FNP ☐ PA ☐ CNM ☐ Other:

- ☐ Approved
- ☐ Approved with modifications (specify below)
- ☐ Denied (specify below)

Comments:

I hereby approve the requested privileges (and any modifications) based on the above-named provider's certification and credentials. I agree that, to the best of my knowledge, they do not have a physical or mental condition that may limit their ability to perform their essential job functions.

Medical Director Date

PRIVILEGE APPROVAL – CLINICAL STAFF COMMITTEE

- ☐ Approved
- ☐ Approved with modifications (specify below)
- ☐ Denied (specify below)

Comments:

Chair, Clinical Staff Committee Date

PRIVILEGE APPROVAL – HEALTHCARE SERVICES COMMITTEE – FCCH BOARD

- ☐ Approved pursuant to as per Medical /Dental Staff /Behavioral Health Staff recommendations
- ☐ Approval with modifications (specify below)
- ☐ Denied (specify below)

Comments:

Chair, Healthcare Services Committee Date

Applicant's Initials_____