First Choice
COMMUNITY HEALTHCARE

APPLICATION FOR CLINICAL PRIVILEGES (MEDICAL)

Granting, reviewing, and changing of clinical privileges for the staff of FIRST CHOICE COMMUNITY HEALTHCARE (FCCH) will be in accordance with the 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:

LEVEL ONE (GENERAL)

This class includes privileges for uncomplicated, basic procedures and clinical application of cognitive skilIs. 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.

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 PRIVIEGES THAT MAY BE CONSIDERED TO BE IN A HIGHER CLASS.

FIRST CHOICE COMMUNITY HEALTHCARE
DELINEATION OF PRIVILEGES FOR

_____

Last First Middle Title

INITIAL EACH BOX FOR EACH PRIVILEGE REQUESTED

PRIVILEGES	**PRIVILEGE REQUESTED**	**CLINICAL SUPERVISOR APPROVAL**	**SPECIAL CONDITIONS/ COMMENTS**
LEVEL ONE			
Management of Routine Pediatric Care			
Management of Routine Adolescent Care			
Management of Routine Adult Care			
Management of Routine Gynecologic Care			
Management of Routine Prenatal Care			
Management of Routine Geriatric Care			
Supervision of Residents & Students			
Cardiopulmonary resuscitation (BLS)			
Initial evaluation of musculoskeletal problems			
Suturing of simple lacerations (one layer)			
Use of local anesthics for wound repair			
Superficial Nerve Block			
Debridement, skin or subcutaneous, tissue			
Treatment uncomplicated dermatological conditions			
Needle aspiration of subcutaneous lesion			
Excision, benign skin lesion			
I&D, Paronychia,			
I&D, uncomplicate soft tissue abscess			
Treatment of planter warts			
Dressing/Debridement, burn			
Foreign body removal, nose			
Foreign body removal, eye (not corneal)			
Foreign body removal, ear			
Incisional removal of foreign body			
EKG Interpretation			
PFT (pulmonary function test) interpretation			
IUD removal			
I&D, Bartholin Cyst			
Waived Laboratory Testing			
Provider Performed Microscopy			

GENERAL PRIVILEGES	PRIVILEGE REQUESTED	CLINICAL SUPERVISOR APPROVAL	SPECIAL CONDITIONS/ COMMENTS
LEVEL TWO			
I&D complicated abscess			
I&D perirectal abscess			
Biopsy, skin			
Ingrown toenail excision			
Joint aspiration and injectionof major joints (i.e. shoulder, hip, knee)			
Lacerations, infected			
Suturing of simple 2 layer lacerations			
Trigger point injection			
Endometrial Biopsy			
IUD insertion			
Cervical Biopsy			
Colposcopy			
Cervical Cryotherapy			
LEEP			
Prenatal care with moderate risk, including • history of genital herpes • mild chronic hypertension • gestastional diabetes • mild pre-eclampsia			
Outpatient subcutaneous heparin/LMW heparin management			
Joint Asprirations			
Procedures involving destruction of nail bed			
Treatment of Closed Dislocations and uncomplicated fractures			
Hyfercation and Fulguration			
ECHO Rheumatology			
ECHO Hepatitis C			
Clincial Cardiology Care			
BEHAVIORAL HEALTH			
Screening for behavioral health needs			
SBIRT intervention			
Psychotrophic medication management			
Buprenorphine (Suboxone) manangement			
Behavioral health counseling			

Psychotherapy (psychiatrist or psychologist only)			
OTHER PROCEDURES/SERVICES			
Special competency based on appropriate experience, training, credentials, or documentation:			

I hereby request the privileges identified above. Furthermore, I certify that I have received and posses the necessary and required professional licensure, education, training, ongoing experience, competence and judegement and that I am qualified for and request the above clinical privileges to perform the above procedures and/or categorical levels of care which I have indicated. I certify that I am physically and mentally capable to perform the above requested privileges.

X _____ _____

Applicant's Signature Date

Applicants DEA# _____

Applicants NPI# _____

- - - - - - - BELOW – FOR FCCH CREDENTIALING DEPT. - - - - - -

_____ _____

Clinical Supervisor Signature Date

PRIVILEGE APPROVALS

_____ _____ ___ _____

Last name First Middle Date of Hire

2. Type of Position: MD DO CNP PA LISW MSW CNM
Other: _____

3. Action:

_____Approved

_____ Approved with modifications (specify below)

_____Denied (specify below)

_____
_____

_____ _____
Medical Director **Date**

4. **Medical/Dental Staff Committee Approval**

_____Regular Approval
_____Approval with modification (Specify below)
_____Denied (Specify below)
_____
_____
_____

_____ _____
Chair, Medical/Dental Staff Committee **Date**

5. **Health Care Services Committee**

____Approved as per Medical Dental Staff recommendation
____Approval with modifications (Specify below)
____Denied (Specify below)

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_____ _____
Chair, Health Care Services Committee **Date**