John C. Lincoln
Deer Valley Hospital

Department of Medicine
ALLERGY AND IMMUNOLOGY
Delineation of Privileges

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Please Print Name

QUALIFICATIONS: Licensed physician (DO or MD) as defined in the Medicine Department Rules and Regulations with appropriate specialty training.

Of the following, indicate particular privileges requested: Privileges granted herein permit the physician to treat patients without limitation, for all inpatient and outpatient areas, intensive care units, and Emergency Department.

REQ=Requested APP=Approved

REQ	APP	PRIVILEGE REQUESTED
		ADMIT, evaluate, diagnose and provide treatment or consultative services to patients presenting with allergic immunologic disorders and conditions.

CORE ALLERGY AND IMMUNOLOGY PRIVILEGES/AREA Of PRACTICE: All allergists are eligible to apply for the following core privileges including the diagnosis and treatment of allergic rhinitis, asthma, allergic eye diseases, atopic dermatitis, urticaria, chronic cough, chronic sinus infections, frequent colds/bronchitis and immune problems. A letter from the residency/fellowship program director confirming training/experience in privileges requested for all new applicants who have recently (within the past 5 years) completed training. Applicants should provide procedural logs from their training program if applicable. Applicants out of training over 5 years must provide documentation of training and recent experience.

REQ	APP	PRIVILEGE REQUESTED
		Allergy and Immunology Core Privileges

I have reviewed the above list and have checked the procedures to which I am limiting my practice; and having been trained accordingly, by my signature below, I certify that my malpractice insurance will cover, to the dollar limits required by the Board of Directors, my exercise of the above requested privileges:

Applicant's Signature:	**Date:**

DEPARTMENTAL REPORT AND RECOMMENDATION: Upon review of all the credentialing information available with particular focus on education/training, experience, current competence and ability to perform the specific privileges requested, I recommend the applicant as capable of carrying out duties and is competent to perform each of the specific privileges as designated above.

Signature: Medicine Department Chairman/Vice Chairman	**Date:**

Date: ________________________ Credentials approval

Date: ________________________ Medical Executive approval

Date: ________________________ Board of Directors approval

2/09