

**Department of Medicine**  
**CLINICAL RESEARCH ONLY**  
Delineation of Privileges

**Please Print Name** \_\_\_\_\_

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

1. All new applicants for clinical research privileges, as members of the medical staff, shall be reviewed with respect to the performance of their clinical abilities. All new applicants in this specialty shall be considered only if they have **successfully completed an Accreditation Council for Graduate Medical Education or the American Osteopathic Board accredited residency program followed by an approved fellowship program in their primary subspecialty.**
2. A letter of reference must come from the director of the applicant's training program in his/her primary subspecialty.
3. Documentation of continuing education related to clinical research.

**Of the following, indicate particular privileges requested:** Privileges granted herein permit the physician to treat patients, for all inpatient and outpatient areas, intensive care units, and Emergency Department.

REQ=Requested APP=Approved

REQ	APP	PRIVILEGE REQUESTED
		Provide consultation for problems related to research; order diagnostic tests and procedures related to problems associated with research; and treat patients with problems related to research.

Req	App	ROUTINE FUNCTIONS PERMITTED
		Examine patients and establish diagnoses by H&P & Consultation related to research
		Order, perform, and interpret tests (including, but not limited to; laboratory, diagnostic imaging, and medications/treatments) related to research
		Identify, develop, implement and evaluate a plan of care for the patient to promote, maintain and restore health related to research
		Refer to, and consult with, appropriate health care providers related to research
		Prescribe schedule II, III, IV or V controlled substances and prescription only drugs, over the counter drugs, medical devices, and appliances related to research

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 meets or exceeds the limits required by the Board of Directors.

<b>Applicant's Signature:</b>	<b>Date:</b>
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**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.

<b>Signature: Medicine Department Chairman/Vice Chairman</b>	<b>Date:</b>
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Date: \_\_\_\_\_  
Credentials approval

Date: \_\_\_\_\_  
Medical Executive approval

Date: \_\_\_\_\_  
Board of Directors approval