

Please Print Name _____

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

INITIAL APPLICANTS

A letter from the residency/fellowship program director confirming training/experience in procedures requested is required for all new applicants who have recently (within the past 5 years) completed training. Applicants should provide a copy of procedural case logs from their training program. Applicants out of training over 5 years must provide documentation of training and recent experience.

RE-APPLICANTS

Physician must be able to show current demonstrated competence and adequate volume of experience in Dermatology reflective of the scope of privileges requested for the past 24 months.

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

STAFF CATEGORY: All Dermatologists are eligible to apply for one of the following categories. Please see requirements as listed below and select appropriate Category. **CHOOSE ONE CATEGORY BELOW:**

1. Affiliate Staff (No Admitting Privileges)
2. Admitting Staff

REQ	APP	(Please select ONE category)
		AFFILIATE STAFF: Affiliate Staff Members shall consist of physicians who do not admit or manage patients in the Hospital but who diagnose or treat patients who use the Hospital.
		ADMITTING: Admit, evaluate, diagnose and provide treatment or consultative services to patients presenting with illnesses or injuries of the integumentary system.

CORE DERMATOLOGY PRIVILEGES/AREA OF PRACTICE: All Dermatologists with **ADMITTING** privileges are eligible to apply for the following core privileges including consultation and the performance of simple excision and repair, skin and nail biopsy, chemosurgery, topical chemosurgery, cryosurgery, electrosurgery, minor cutaneous surgery including biopsy, patch and photo patch testing.

REQ	APP	PRIVILEGE REQUESTED
		Dermatology Core Privileges

I have reviewed the above list and have checked the procedures to which I am limiting my practice; and have been trained accordingly. By my signature below, I certify that my malpractice insurance meets or exceeds the limits required by the Board of Directors

Applicant's Signature:	Date:
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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.

Signature: Medicine Department Chairman/Vice Chairman	Date:
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Date: _____
Credentials approval

Date: _____
Medical Executive approval

Date: _____
Board of Directors approval