

**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 neuromuscular or musculoskeletal disorders.
<p><b>CORE PHYSICAL MEDICINE AND REHABILITATION PRIVILEGES/AREA OF PRACTICE:</b> All Physical Medicine and Rehabilitation Physicians are eligible to apply for the following core privileges including nerve conduction studies and electromyography. <b>To request sub-specialty privileges in Pain Management, please see the Pain Management Section on the Anesthesiology Delineation of Privileges Form (Department of Surgery).</b> 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.</p>		
REQ	APP	PRIVILEGE REQUESTED
		Physical Medicine and Rehabilitation 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:

<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