

**JOHN C. LINCOLN NORTH MOUNTAIN HOSPITAL
DEPARTMENT OF MEDICINE
INFECTIOUS DISEASE
Delineation of Privileges**

PHYSICIAN 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 Infectious Disease for the past 24 months reflective of the scope of privileges requested.

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

REQ=Requested APP=Approved

REQ	APP	PRIVILEGE REQUESTED
		ADMIT , evaluate, diagnose and provide treatment or consultative services solely to patients presenting with infectious or immunologic conditions/diseases and illnesses caused by microorganisms. These privileges do not include the privilege to admit patients with general Internal Medicine or Family Practice diseases.
CORE INFECTIOUS DISEASE PRIVILEGES/AREA OF PRACTICE: All Infectious Disease Physicians are eligible to apply for the following core privileges including the incision and drainage of abscesses of the skin and adjacent soft tissue, needle aspirations of accessible foci of infection and microscopic examination and interpretation of specimens obtained from infected sites.		
REQ	APP	PRIVILEGE REQUESTED
		Infectious Disease Core

- *I have reviewed the above list and have checked the procedure(s) to which I am limiting my practice; and having been trained accordingly I am requesting permission to do these procedures.*
- *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		
APPROVALS:			
SIGNATURE: Department Chairman/Designee	Date		
Executive Committee	Date	Board of Directors	Date