Delineation of Privileges in Family Practice Ambulatory Care
Primary Care Practitioners (Physicians and Mid-Level Practitioners)

Applicant's Name: _____ Title: _____

(Main Center, except **BOLD PRINT** procedures apply to both the Main Center and KHC-Path Valley FOR PHYSICIANS)

CATEGORY I CORE PRIVILEGES: Physicians requesting these privileges must be certified or eligible for certification by the appropriate professional organization.

Practice/Procedure	Current	Requested	Provisional	Recommended
1. Outpatient Obstetrical Care: general dx and tx				
2. Outpatient Adult Medical Care: "				
3. Outpatient Pediatric Care: "				

CATEGORY II PRIVILEGES: Practitioner requesting these privileges must meet the requirements for Category I and show documentation of appropriate training and continued proficiency.

Practice/Procedure	Current	Requested	Provisional	Recommended
1. Circumcision of newborn				
2. Colposcopy and biopsy				
3. Cervix cryosurgery				
4. **EKG interpretation**				
5. Endometrial biopsy				
6. Flexible sigmoidoscopy and biopsy				
7. Vasectomy				
8. **IUD insertion & removal**				
9. **Norplant insertion & removal**				
10. **Fracture care: non-operative/non-displaced**				
11. **Joint aspiration**				
12. **Injection of joint, tendon, bursa**				
13. **Nail matrix destruction**				
14. **Laceration repair**				
15. **Incision & drainage of abscess**				
16. **Biopsy skin and subcutaneous**				
17. **Sebaceous cyst treatment or excision**				
18. **Venereal warts treatment**				
19. **Foreign body removal: eye**				
20. Nasal laryngoscopy				
21. **Foreign body removal: ear, nose, throat**				
22. Bladder catheterization				
23. **Child abuse/Sexual assault evaluation**				
24. **Infusion therapy**				

* **Applicant attests that clinical training provided adequate instruction and experience for requested privileges.**
* **Any restriction on clinical privileges granted is waived in an emergency situation.**
* **Clinical privileges expire and must be renewed after two years.**

Signatures of applicant and Medical Director affirm the ability of applicant to perform the mental and physical tasks necessary for the scope of practice requested.

Signature of Applicant _____ Date _____

Signature of Chief Medical Officer_____ Date _____

Signature of Secretary, Board of Directors _____ Date _____