### Delineation of Privileges

**NAME:**

**CATEGORY I: CORE INTERNAL MEDICINE PRIVILEGES**

<table>
<thead>
<tr>
<th>Core Internal Medicine Privileges include:</th>
<th>Requested</th>
<th>Approved</th>
</tr>
</thead>
</table>

Clinical privileges to care for adult patients and when necessary, to render emergency care to assist with stabilization of pediatric patients prior to transfer to a higher level of care. Pediatric patients are defined as those younger than 15 years.

1. Admit patients 16 years and older, order diagnostic/therapeutic services, history and physical, write orders/progress notes in patient charts, request/provide consultation, and render any care in life threatening emergency.
2. Treatment of patients 16 years through old age through all stages of acute and chronic medical illness.
3. Procedures include:
   - Medical Cardioversion
   - Nasogastric tube insertion
   - EKG interpretation
   - Skin biopsy
   - Lumbar Puncture

**CATEGORY II: SPECIAL INTERNAL MEDICINE PRIVILEGES**

<table>
<thead>
<tr>
<th>Special internal medicine procedures which may require additional documentation of training/proficiency; PLEASE INDICATE IF REQUESTING “FOR EMERGENCY ONLY”</th>
<th>Requested</th>
<th>Approved</th>
</tr>
</thead>
</table>

1. Flexible sigmoidoscopy (emergency only)
2. Bone marrow
3. Graded exercise stress testing
4. Thoracentesis
5. Paracentesis
6. Joint aspiration
7. Joint instillation
8. Suturing

**CATEGORY III: CRITICAL CARE PRIVILEGES**

<table>
<thead>
<tr>
<th>Special advanced critical care procedures which will require additional documentation of training/proficiency and should be attached to this request. PLEASE INDICATE IF REQUESTING “FOR EMERGENCY ONLY”</th>
<th>Requested</th>
<th>Approved</th>
</tr>
</thead>
</table>

1. Patient management in the critical care units
2. Swan-Ganz catheter placement
3. Temporary pacemaker insertion
4. Arterial cannula placement
5. Endotracheal intubation
6. CVP line placement
7. Ventilatory support management
8. Chest tube insertion
9. Cut Down
10. PICC

**OTHER PRIVILEGES REQUESTED:**

1.
I hereby certify that I possess the training, skill, experience, and current competency for the clinical privileges I have requested and pledge to practice within the limitations and scope of these privileges.

Physician Signature ____________________________ Date _________

APPROVAL:

Chief of Medicine [ ] Hospitalist Medicine [ ] Date _________