Privileges in Ambulatory Treatment Infusion Centers

Name:

Instructions:

1. Click the **Request** checkbox to request a group of ***Core Privileges.***
2. **Uncheck** any privileges you do not want to request in this group.
3. Individually check off any **Special Privileges** you want to request.
4. Sign form electronically and **submit with all required documentation**.

Required Qualifications	
Education/Training	Successful completion of an ACGME or AOA accredited Education/Training in your specialty or foreign equivalent training.
Certification	Current certification or active participation in the examination process leading to certification in your specialty by the appropriate American Board or American Osteopathic Board or foreign equivalent training/board.
Clinical Experience (Initial)	Certification as stated above.

Ambulatory treatment infusion centers Core

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Service Chief Rec ☐
☐	Privileges to manage and coordinate patient care, treatment, and services ONLY in a SHC ambulatory treatment infusion center, including diagnostic tests and treatment. Treatment would include infusion therapy, chemotherapy, or blood administration. Must provide history and physical for initial treatment and must designate contact physician. Renewal -Minimum of 6 cases required in the past 2 years]	☐

FPPE - Area is managed by Medical Staff Office. Please make NO selections

☐ Core - Ambulatory Treatment Infusion Center: (Chart review)

Refer and Follow Privileges

Description: Must meet core criteria

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Service Chief Rec ☐
☐	Privileges to refer and follow patients requiring hospitalization. Includes visiting patient, review of the medical record and observation of procedures. Privileges do not include providing clinical services to the patient	☐

Acknowledgment of Applicant

I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at Stanford Hospital & Clinics. I also acknowledge that my professional malpractice insurance extends to all privilege I have requested.

I acknowledge I have met the minimum number of cases required as identified for privileges.

I understand that in exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

By clicking on the "Submit" button below, I have electronically signed, dated and submitted this privilege request

Date

Service Chief Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

Service Chief Recommendation - Proctoring Requirements

Service Chief/Designee - By clicking on the 'Submit' button below, I have electronically signed, dated and approved this privilege request

Date

Submit