

**Harris Methodist Southlake
Center for Diagnostics and Surgery**

Core Privileges in Internal Medicine

Name: _____

Please indicate with a check mark the privileges requested.

Qualifications

To be eligible to apply for core privileges in internal medicine, the applicant must meet the following qualifications:

- Documentation of the provision of inpatient services to at least 60 patients in the last two years;
- and**
- Current certification or eligibility to participate in the examination process leading to certification in internal medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine;
- and**
- Successful completion of an ACGME- or AOA-accredited residency in internal medicine.

_____ **Privileges included in the core**

Privileges to work-up, diagnose, and provide non-surgical treatment, in a consultative role for patients age 16 and over admitted or in need of care to treat general medical problems, including EKG interpretation, except for those special procedure privileges listed below.

Special procedures privileges

To be eligible to apply for a special procedure privilege listed below, the applicant must request core internal medicine privileges. Applicant must also demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth here.

Procedure	Criteria	Requested	Recommended	Not Recommended
Insertion and management of pulmonary artery catheter	7 cases			

****If the procedure that you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and experience.**

Acknowledgement of practitioner

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 **Harris Methodist Southlake**, and

I understand that:

(a) 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.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed: _____

Date: _____

Credentials Committee Recommendations: _____ **Recommend** _____ **Deny**

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Signed: _____

Date: _____

Recommended/Not recommended with the following modification(s) and reason(s):

