Surgical Privileges Form: Dermatology

Clinical Privileges Request

Applicant's Name: ……..…… Scope of Practice: …….

License No. (If Any): ……..…… Facility: ……..

Date:…….……

Privileges	***For applicant use***		***For committee use***		
	Request	*Signature*	*Recommen -ded*	*Not Recommended*	*Signature*

Category I: Advanced Privileges

1. Photo therapy					
2. Melanocyte					
3. Dermatopathology					
4. Sclerotherapy					

Category II: Additional Privileges

1.					
2.					
3.					
4.					
5.					

Notes:

- If additional privilege(s) are desired, please indicate this in the space provided above.
- You must submit along with this application all necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.
- Granting privileges under supervision is no longer permitted

By signing below, I acknowledge that I have read, understand, and agree to abide by QCHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

a) In exercising any clinical privileges granted, I am constrained by QCHP's 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 situation my actions are governed by the recognized policies and rules.

…….. ……
Applicant's signature (Stamp if any) Date

1. …….. ……
Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signature Date

For Committee use only

Evaluation Committee Chairman:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and I have made the above-noted recommendation(s).

…….. ……

Chairperson's Stamp & signature Date

Other Committee Members:

…….. ……

1) Name Date

…….. ……

2) Name Date