Surgical Privileges Form: Dermatology (Core Privileges)

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

Core Privileges

Privileges	Request	Signature	Recommended	Not Recommended	Signature
1. History taking, local skin examination and description of skin lesions with subsequent topical applications description.					
2. Dermojet					
3. Punch Biopsy					
4. Intralesional					
5. Curettage					
6. Comedone extraction					
7. Liquid nitrogen application (cryocautery)					
8. Skin Paring (warts/superficial keratosis/callosity)					
9. Electrocautery					
10. Local Chemical cautery					
11. Removal of sutures					

12. Minor skin surgery (with local anesthesia)					
13. Laser therapy					
14. Chemical peeling					
15. DTM culture (fungus)					
16. KOH scrapings					
17. Methylin blue					
18. Botux injection					
19. Patch test					
20. Wood's light					
21. Crystal peel(Microdermabrasion)					
22. Dermal fillers					
23. PRP					

Note:

- 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

…………………………………………………….. …………………………
1) Name Date