NAME _____________________________

Fort Hamilton Hospital
Specialty: Medicine - Dermatology
Delineation of Privileges

**Required Qualifications**

**Education/Training/Experience**
Must have successfully completed an ACGME/AOA-accredited residency in Dermatology. The successful applicant for initial appointment must provide documentation of provision of outpatient or consultative care, reflective of the scope of privileges requested, to at least 12 patients in the past 12 months or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship or research in a clinical setting within the past 12 months.

**Certification**
The applicant physician must possess current board certification by the specialty board most commonly applicable to his or her specialty, or become board certified as such within six years of completing his or her residency program or receiving medical staff membership or clinical privileges.

**Reappointment Criteria of Dermatology Core Privileges**
To be eligible to renew core privileges in Dermatology, the applicant must demonstrate competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.
CORE PRIVILEGES IN DERMATOLOGY

Core Privileges include admit (if requested), evaluate, diagnose, treat, and provide consultation to patients with benign and malignant disorders of the integumentary system (epidermis, dermis, subcutaneous tissue, hair, nails, mouth, external genitalia, and cutaneous glands) as well as sexually transmitted diseases. Assess, stabilize, and determine disposition of patients. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

Request all privileges listed below.

*Uncheck any privileges that you do not want to request.*

- Admit and manage patients in non-critical care and unmonitored settings
- Perform History and Physical Examinations
- Consultation privileges in Dermatology
- Botulinum toxin injection
- Chemical face peels
- Collagen injections
- Cryosurgery
- Dermabrasion
- Diagnosis and treatment of skin cancers, moles, and other tumors of the skin
- Electrosurgery
- Excision of benign and malignant tumors with simple, intermediate and complex repair techniques including flaps and grafts
- Interpretation of specially prepared tissue sections, cellular scrapings, and smears of skin lesions by means of routine and special (electron and fluorescent) microscopes
- Management of contact dermatitis, allergic and nonallergic skin disorders, skin manifestations of systemic (including internal malignancy), and infectious diseases
- Management of cosmetic disorders of the skin such as hair loss and scars and the skin changes associated with aging
- Patch tests
- Scalp surgery
- Sclerotherapy
- Skin and nail biopsy
- Soft tissue augmentation

SPECIAL PRIVILEGES – Dermatology

The below special privileges are not routinely part of the post-graduate training program. Additional proof of training and/or experience may be necessary to request the privilege and is noted within the privilege block. If documentation is required, please submit all required elements with your application/reapplication.

**Laser**

Successful completion of an approved residency in a specialty or subspecialty that included training in laser principles or provide documentation appropriate to the specific laser to be utilized. Practitioner agrees to limit practice to only the specific laser types for which they have been provided documentation of training and experience.
Acknowledgement of Applicant

I hereby request the clinical privileges in the Department of Medicine as indicated. I understand that such privileges include rendering of all associated diagnostic and supportive measures necessary in performance of the privileges I have requested, and in treating associated diseases with adequate consultation when indicated.

I recognize that in emergency situations where immediate life-saving action is necessary, any member of the medical staff is authorized to perform such life-saving treatment as may be required.

I further understand that any and all privileges granted me in the Department of Medicine shall be commensurate with my documented training and demonstrated competence, judgment and capabilities. The Credentials and Executive Committees of the medical staff and the Board of Trustees of the hospital reserve the right to grant or limit my privileges in accord with my continuing performance in rendering patient care.

________________________________________________  ________________________________
Practitioner’s Signature                        (Date)

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Print Name