NAME ______________________________________

Fort Hamilton Hospital
Specialty: Medicine - Telestroke
Delineation of Privileges

Instructions:
1. Check the Request checkbox to request all privileges in the Core group.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign/Date form and Submit with required documentation.

Required Qualifications

Education/Training/Experience
Must have successfully completed an ACGME/AOA-accredited residency/fellowship in Emergency Medicine, Neurology or Neurocritical Care Medicine. The successful applicant for initial appointment must provide documentation of provision of care, reflective of the scope of privileges requested, during 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 Telestroke Core Privileges
To be eligible to renew core privileges in Telestroke, 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 TELESTROKE

Please indicate the privileges requested with a (√):

| Confer / observe remotely, via the internet, patients being treated at Fort Hamilton Hospital (FHH), assess such patients’ medical care needs and advise FHH Emergency Department physicians and other physicians as appropriate on treatment of stroke patients. FHH physicians will write any applicable orders after consultation with the telestroke physician. |

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) ____________________________

Print Name ____________________________