NAME ________________________________

Fort Hamilton Hospital
Specialty: APHERESIS – Surgery/Pathology
Delineation of Privileges

Required Qualifications

Education/Training/Experience
Must have successfully completed an ACGME/AOA-accredited residency in clinical or a combined residency in anatomic and clinical pathology, with achievement of certification within six years of residency completion, leading to certification in clinical and/or anatomic pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or subspecialty certification in Blood Banking.

The successful applicant for initial appointment must provide documentation successful completion of an ACGME- or AOA-accredited residency and/or clinical fellowship and demonstrated current competence relevant to the scope of privileges requested.

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 Apheresis Core Privileges
Current demonstrated competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months.
**CORE PRIVILEGES IN THERAPEUTIC APHERESIS**

<table>
<thead>
<tr>
<th>Request all privileges listed below.</th>
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<tbody>
<tr>
<td><em>Uncheck any privileges that you do not want to request.</em></td>
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<tr>
<td>Consultation privileges in Apheresis</td>
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<tr>
<td>Plasma exchange, red cell exchange, leukopheresis, plateletapheresis, and immunoadsorption</td>
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<tr>
<td>Order diagnostic studies and tests</td>
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**Acknowledgement of Applicant**

I hereby request the clinical privileges in the Department of Surgery 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 Surgery 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 ___________________________________________________________