DEPARTMENT OF PATHOLOGY
Core Privileges

Name: ____________________________

Purpose
Physicians who are members of the Department of Pathology, will provide quality anatomic pathology services and strive to ensure prompt, efficient and accurate clinical laboratory services for all patients.

Qualifications
To be eligible for core privileges in the Department of Pathology, the applicant must meet the following qualifications:

- Successful completion of an ACGME or AOA-recognized accredited residency program in anatomic pathology;
- Demonstration of the provision of pathology services to at least 100 patients in the past two years;

Active participation in the examination process leading to certification in pathology or current certification by the American Board of Pathology or the American Osteopathic Board of Pathology is highly recommended.

Privileges included in the core with observation requirements

☐ Requested

Privileges include, but are not limited, to: General anatomical, clinical, dermato-, cyto-, neuro- and radioisotope pathology and management of the blood bank and immunohematology (blood bank or transfusion medicine); autopsy; performance and interpretation of bone marrow aspiration/biopsy, frozen section, and fine needle aspiration of palpable superficial masses; and interpretation and evaluation of special laboratory tests and procedures in in-vitro radioisotope techniques, except for those special procedure privileges listed below.

Observation Requirements for core medical privileges - Applicants for Active staff are required to have 10% of their cases from the first 3 months reviewed by the Department Chairman.

Biennial renewal benchmarks – Demonstrated current competence.

☐ Requested ☐ Recommended ☐ Not Recommended

☐ Recommended with the following modification(s) and reason(s):

Approved:
Department of Pathology:  6/14/05
Credentials Committee:  7/14/05
PSEC:  7/25/05
Special procedures privileges with observation requirements
To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth in the medical staff policies governing the exercise of specific privileges.

<table>
<thead>
<tr>
<th>Privilege</th>
<th>Training/Experience/Observation</th>
<th>Biennial Renewal Benchmarks</th>
<th>Requested</th>
<th>Recommend</th>
<th>Do Not Recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate Sedation</td>
<td>If requested, specific privileging information will be forwarded to you.</td>
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<tr>
<td>Other:</td>
<td></td>
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</table>

Comments:_____________________________________________________________________________________
___________________________________________________________________________________________

Provisional year chart review requirement
All of the extension cases will be retrospectively reviewed, during the quality improvement process, during the first year at 6 and 12month intervals.

If there is not a sufficient level of activity during the provisional period, recommendations for privileges or an extension of provisional status will be at the discretion of the department chair.

Acknowledgement of practitioner
I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at McLaren Greater Lansing, and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff 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 a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed: ___________________________________________ Date: ________________
Name: ____________________________________________________________

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(for office use only)

Recommendation:

( ) Approve as requested
( ) Approve with modifications as noted below
( ) Denial of privileges

Modifications: __________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Observers: ____________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

I (we) attest that in recommending these privileges, due consideration has been given to the applicant’s professional performance, training, experience, judgment, and technical skills.

Chairman, Department of Pathology                                           Date

Co-Chief of Staff (for interim privileges only)                           Date

Action:
Credentials Committee                                                   Date: ______________________

Professional Staff Executive Committee:                                  Date: ______________________

Board of Trustees                                                        Date: ______________________

Comments: ____________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Approved: Department of Pathology: 6/14/05
Credentials Committee: 7/14/05
PSEC: 7/25/05