



**Delineation of Privileges
Department of Medicine
INTERNAL MEDICINE - ENDOCRINOLOGY**

Name: _____

MINIMUM QUALIFICATIONS FOR PRIVILEGES:

- Practitioners must be duly licensed to practice in the State of Florida and hold a valid DEA certificate.
- Successful completion of an ACGME or AOA-accredited residency/fellowship in endocrinology.
- Current certification or active participation in the examination process leading to certification in Endocrinology by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.

CATEGORY I: CORE PRIVILEGES

General: ENDOCRINOLOGY AND INTERNAL MEDICINE	Requested	Approved
1. Admit patients 16 years and older, order diagnostic/therapeutic services, history and physical write orders/progress notes in patient charts, request/provide consultation, and render any care in life threatening emergency.		
Core Privileges/Procedures - ENDOCRINOLOGY	Requested	Approved
1. Comprehensive examination, consultation, diagnosis and treatment of diseases of the endocrine system to include management of hormone delivery systems, management of diabetes with home glucose monitoring, interpretation of static and dynamic endocrine function, analysis of lipoprotein phenotypes and interpretation of lipoprotein electrophoresis.		
Core Privileges/Procedures - INTERNAL MEDICINE	Requested	Approved
1. Treatment of patients 16 years through old age through all stages of acute and chronic medical illness. 2. Procedures include: <ul style="list-style-type: none"> ➢ Medical Cardioversion ➢ Nasogastric tube insertion ➢ EKG interpretation ➢ Skin biopsy ➢ Lumbar Puncture 		
CATEGORY II: SPECIAL ENDOCRINOLOGY PRIVILEGES		
ENDOCRINOLOGY: <i>Special procedures which may require documentation of additional training/experience:</i>	Requested	Approved
1. Performance of dynamic endocrine testing		
2. Radioactive iodine therapy of Graves disease, thyroid cancer, and hyperthyroidism		
3. Management of severely obese patient on hypocaloric diets		
4. Management of continuous subcutaneous insulin infusion pump therapy		
OTHER:		
5.		
6.		
7.		

Name: _____

CATEGORY II: SPECIAL INTERNAL MEDICINE PRIVILEGES		
Special internal medicine procedures <i>which may require additional documentation of training/proficiency; PLEASE INDICATE IF REQUESTING "FOR EMERGENCY ONLY"</i>	Requested	Approved
1. Flexible sigmoidoscopy		
2. Bone marrow		
3. Graded exercise stress testing		
4. Thoracentesis		
5. Paracentesis		
6. Joint aspiration		
7. Needle Aspiration Biopsy of Thyroid		
OTHER:		
8.		
9.		
CATEGORY III: CRITICAL CARE PRIVILEGES		
Special advanced critical care procedures <i>which will require additional documentation of training/experience.</i>	Requested	Approved
1. Patient management in the critical care units		
2. Swan-Ganz catheter placement		
3. Temporary pacemaker insertion		
4. Arterial cannula placement		
5. Endotracheal intubation		
6. CVP line placement		
7. Ventilatory support management		
8. Chest tube insertion		
9. Cut Down		
OTHER PRIVILEGES		
Please specifically list any additional privileges or procedures you are requesting (if you still practice Internal Medicine, request Internal Medicine privilege list):	Requested	Approved
1.		
2.		
3.		
4.		

I hereby certify that I possess the training, skill, experience, and current competency for the clinical privileges I have requested and pledge to practice within the limitations and scope of these privileges. Category II and III privileges cannot be requested or approved without requesting and approving Category I Core privileges.

 Physician Signature

 Date

APPROVAL:	
_____ Chief of Medicine	_____ Date