



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

Name: _____

MINIMUM QUALIFICATIONS FOR PRIVILEGES:		
<ul style="list-style-type: none"> 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 rheumatology. Current certification or active participation in the examination process leading to certification in Rheumatology by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine. 		
CATEGORY I: CORE PRIVILEGES		
Core Privileges/Procedures - INTERNAL MEDICINE	Requested	Approved
<ol style="list-style-type: none"> 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. 2. Treatment of patients 16 years through old age through all stages of acute and chronic medical illness. 3. Procedures include: <ul style="list-style-type: none"> > Medical Cardioversion > Nasogastric tube insertion > EKG interpretation > Skin biopsy 		
Core Privileges/Procedures - RHEUMATOLOGY	Requested	Approved
<ol style="list-style-type: none"> 1. Comprehensive examination, consultation, diagnosis and treatment of disorders of connective tissue. 2. Arthrocentesis, soft tissue injections, assessment of bone and joint radiographs, applied use of immunosuppressive and specific disease remittive agents. 		
CATEGORY II: SPECIAL PROCEDURES		
INTERNAL MEDICINE: <i>Special procedures which may require documentation of additional training/experience:</i>	Requested	Approved
1. Arterial cannula placement		
2. Thoracentesis		
3. Paracentesis		
4. Joint Aspiration - specify joint(s):		
5. Bone Marrow		
6. Esophageal Manometry		
7. Temporary Pacemaker Insertion		
OTHER: (please list):		
8.		
9.		
RHEUMATOLOGY: <i>Special procedures which may require documentation of additional training/experience:</i>	Requested	Approved
1. Arthroscopy		
2. Synovial biopsy		
3. Arthrocentesis		
OTHER: (please list):		
3.		
4.		
5.		
6.		

Name: _____

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		

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:	
_____ <i>Chief of Medicine</i>	_____ <i>Date</i>