



**Delineation of Privileges
Department of Medicine
NEUROLOGY**

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 Neurology. Current certification or active participation in the examination process leading to certification in Neurology by the American Board of Psychiatry & Neurology or the American Osteopathic Board of Neurology & Psychiatry. | | |
| CATEGORY I: CORE PRIVILEGES | | |
| Core Privileges <i>include:</i> | Requested | Approved |
| <ol style="list-style-type: none"> 1. Admit patients, order diagnostic/therapeutic services, write orders/progress notes in patient charts, request/provide consultation, and render any care in life threatening emergency. 2. Comprehensive examination, consultation, diagnosis and treatment of diseases of the central and peripheral nervous systems including the brainstem, spinal cord, meninges, skull and spine, and, motorend plates. 3. Core procedures include lumbar puncture, electroencephalography (recording and interpretation), electromyography and nerve conduction velocity studies, evoked potentials (auditory, visual, and somatosensory), myelography, and muscle biopsy. | | |
| CATEGORY II: SPECIAL PROCEDURES | | |
| Advanced Procedures <i>which may required additional training/experience</i> | Requested | Approved |
| <ol style="list-style-type: none"> 1. Management of patients in the critical care units. | | |
| Other (please list): | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 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 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> |