

**UNIVERSITY OF MARYLAND MEDICAL CENTER**  
**Department of Medicine, Division of Pulmonary & Critical Care Medicine**  
**Delineation of Privilege Form**

Applicants for membership in the Department of Medicine, Division of Pulmonary & Critical Care Medicine of the University of Maryland Medical Center may request admission to the Active staff or the Courtesy staff.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please indicate the Staff Category to which you wish to apply:** (refer to Medical Staff Bylaws for qualifications)  
 \_\_\_\_\_ **Active**                      \_\_\_\_\_ **Courtesy**

Please check where privileges will be performed:

\_\_\_ UHC: Transplant Clinic      \_\_\_ UHC: Medical Specialties      \_\_\_ University Medical Center      \_\_\_ All Sites

Privilege/Operative Procedure	Check (√) if Requested	Chair Approval Initial if Yes Write Not Approved if No
<b>Category 0:</b> In the case of an emergency, any member of the Medical Staff, to the degree permitted by his/her license and regardless of Medical Staff status, service or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. <i>*Approved per the Medical Staff Bylaws</i>	√*	Yes
<b>Category I – Core Privileges:</b> To be eligible for core privileges, applicants must have completed an ACGME approved Internal Medicine residency program and be Board Certified or Equivalent (or a candidate for Board Certification)		
<b>Outpatient/Ambulatory Services:</b> Practitioners granted core privileges in ambulatory care will provide services to patients in various outpatient clinic settings. The practitioner will routinely interact with patients as the primary care or ambulatory care provider. Services include: <ul style="list-style-type: none"> <li>• General patient examination and care involving observation, assessment, planning, implementation and evaluation.</li> <li>• Ordering, Interpreting, and evaluating diagnostic tests to identify and assess patients' clinical problems and health care needs.</li> <li>• Performs Preventative health care counseling and instructs patients and/or families on treatment plans.</li> </ul> <b>Ambulatory Service locations are as follows:</b>		
<b>UHC: Transplant Clinic:</b> Privileges include ambulatory core privilege listed above in addition to: thyroid biopsy, injection, trigger point, thoracentesis, I&D abcess-simple, anoscopy, lumbar puncture		
<b>UHC: Medical Specialties:</b> Privileges include ambulatory core privilege listed above in addition to: thyroid biopsy, injection, trigger point, thoracentesis, I&D abcess-simple, anoscopy, lumbar puncture		
<b>UMMC Services:</b> Core privileges include but are not limited to cardioversion, central venous catheter insertion, gastric intubation, electrocardiogram review, thoracentesis, paracentesis, arterial blood gas analysis, pelvic examination, proctosigmoidoscopy, arthrocentesis, open wound culture, placement of urethral catheter, lumbar puncture, arterial line insertion, supervision of pulmonary function tests, supervision of exercise testing, supervise and interpret inhalation challenge studies.		

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Privilege/Operative Procedure	Check (√) if Requested	Chair Approval Initial if Yes Write Not Approved if No
<b>Category II:</b> to be eligible for Category II privileges, applicants must have completed an ACGME approved <u>Pulmonary and/or Critical Care Medicine</u> Fellowship program, be Board Certified or Equivalent (or be a candidate for Board Certification), and provide documentation as to course work and recent experience. <b>Category II privileges are as follows:</b>		
Oral/nasal intubation		
Fiberoptic bronchoscopy		
Transbronchial biopsy		
Transtracheal/bronchial needle aspirate		
Needle biopsy of the pleura		
Ventilator management		
Pulmonary function test interpretation		
Placement of pulmonary artery balloon catheters		
Insertion and management of chest tubes		
Pleurodesis		
Insertion of esophageal balloon		
Temporary transvenous pacemaker placement		
Gastroesophageal balloon tamponade		
Pericardiocentesis		
Percutaneous tracheostomy		
Percutaneous Fine Needle Aspirate		
SCOOP placement		
Continuous venovenous hemofiltration		
Interpretation of cardiopulmonary exercise studies		
Dialysis		
<b>Category III:</b> to be eligible for Category III privileges, applicants must have completed an ACGME approved <u>Pulmonary or Critical Care Medicine</u> fellowship program, be Board Certified or Equivalent (or be a candidate for Board Certification), and provide documentation as to course work and recent experience. <b>Category III privileges are as follows:</b>		
Interpretation of sleep studies ( <i>requires separate certification</i> )		
Endobronchial balloon dilation ( <i>Must have completed 5 cases in 2 years</i> )		
Placement of endobronchial stents ( <i>Must have completed 5 cases in 2 years</i> )		
Placement of brachytherapy catheters ( <i>Must have completed 5 cases in 2 years</i> )		
Right heart catheterization		
Laser treatment of obstruction or bleeding endobronchial lesion ( <i>*separate laser application required—see below</i> )		
Insertion of endobronchial occlusion catheter for hemoptysis		
<b>Category IV: Special/Cross Disciplinary Procedures:</b>		
Moderate (Conscious) Sedation - Criteria for Approval: 1. Proof of Current BCLS certification (please attach); 2. Completion of age-appropriate basic airway management in-service by the UMMC Department of Anesthesia (and every two years thereafter for reappointment). (Physicians board certified in Anesthesiology, Critical Care Medicine, Emergency Medicine, Neonatology, or Oral & Maxillofacial Surgery are not required to fulfill criteria 2.)		

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Privilege/Operative Procedure	Check (√) if Requested	Chair Approval Initial if Yes Write Not Approved if No
<b>Laser Privileges (separate application required)</b>		
Carbon Dioxide		
Argon		
Nd-Yag		
<b>Ultrasound Procedures (please list)</b>		

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Jeffrey D. Hasday, MD  
Division Chief, Pulmonary & Critical Care Medicine

\_\_\_\_\_  
Date

\_\_\_\_\_  
Stephen N. Davis, MBBS, FRCP, FACP, Department Chairman

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Confirming Signature  
(required if any requested privilege is not approved)

\_\_\_\_\_  
Date

**UNIVERSITY OF MARYLAND MEDICAL CENTER  
APPLICATION FOR INITIAL PRIVILEGES FOR CLINICAL USE OF LASERS**

NAME: \_\_\_\_\_

DEPT/DIVISION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

For which type of laser are you applying for privileges?

<b>Carbon Dioxide</b> _____ <b>Argon</b> _____ <b>Nd-YAG</b> _____ <b>Other</b> _____
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Approximately how many cases have you done with the laser?

<b>Carbon Dioxide</b> _____ <b>Argon</b> _____ <b>Nd-YAG</b> _____ <b>Other</b> _____
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For what types of surgery do you use the laser? \_\_\_\_\_

\_\_\_\_\_

**Formal courses taken in laser surgery:** Specify title of course, which types of lasers were used, institution where you took the course, date taken, number of hours of hands-on supervised use of the laser, CME credits earned. Enclose copy of CME certificate for the course.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Training with lasers during residency and/or during practice:** Where it occurred, who supervised you, number of cases done with supervision, dates.

\_\_\_\_\_

\_\_\_\_\_

After completing this form, please return it to the Department of Medical Staff and Graduate Medical Services, 29 South Greene Street, Room 420, Baltimore, MD 21201.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department/Division Chief

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by Credentials Committee Member

\_\_\_\_\_  
Date

**UNIVERSITY OF MARYLAND MEDICAL CENTER  
APPLICATION FOR RECERTIFICATION FOR CLINICAL USE OF LASERS**

NAME: \_\_\_\_\_

DEPT/DIVISION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

**Current privileges are for the following lasers:**

Carbon Dioxide \_\_\_\_\_ Argon \_\_\_\_\_ Nd-YAG \_\_\_\_\_ Other \_\_\_\_\_

*Please list the type of laser and procedures for which you are requesting continued privileges. (Use additional pages if needed for the following information.)*

TYPE OF LASER	PROCEDURES

*List the laser cases which you have done in the past two years:*

TYPE OF LASER	PROCEDURE	NUMBER DONE	NUMBER AND TYPE OF COMPLICATIONS, IF ANY

Since your original certification, have you had any further formal courses in laser surgery? If so, specify title of course, which types of lasers were used, institution where you took the course, date taken, number of hours of hands-on supervised use of the laser, CME credits earned. Enclose copy of CME certificate for the course.

\_\_\_\_\_

\_\_\_\_\_

After completing this form, please return it to Medical Staff Services, 110 South Paca Street, 8<sup>th</sup> Floor, Baltimore, MD 21201, or fax to 410-328-6433.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department/Division Chief

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by Credentials Committee Member

\_\_\_\_\_  
Date