

**Shock Trauma Center
Delineation of Clinical Privileges
Section of Infectious Disease**

Type of Request: ____ Initial ____ Renewal

Name: _____ Date: _____

Please check areas in which privileges are requested.

Procedures	Check if Privilege Requested	Chair Approval Initial if Yes Write No if Not Approved
Infectious Disease Consults		
Prescribe antimicrobial agents restricted to infectious disease specialists		
Thoracentesis		
Paracentesis		
Arthrocentesis		
Other (please Specify):		

Applicant's Signature Date

Chief, Infectious Disease Date
Shock Trauma Center

Clinical Director
Shock Trauma Center

Applicant Verification Signature Date
(to be completed if privilege(s) is/are not approved)