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, Critical Care Medicine Date

Shock Trauma Center

_____ _____
Clinical Director Applicant Verification Signature Date
Shock Trauma Center (to be completed if privilege(s) is/are not approved)