PEDIATRIC HEMATOLOGY/MEDICAL ONCOLOGY CLINICAL PRIVILEGES

Name: _____

Effective From ____/____/_____ To ____/____/_____

☐ Initial Appointment (initial privileges)
☐ Reappointment (renewal of privileges)

- Privileges granted may only be exercised at the site(s) and/or setting(s) that have sufficient space, equipment, staffing, and other resources required to support the privilege.
- The core procedure list (if applicable) is not intended to be an all-encompassing procedure list. It defines the types of activities/procedures/privileges that the majority of practitioners in this specialty perform at this organization and inherent activities/procedures/privileges requiring similar skill sets and techniques. Applicants wishing to exclude any procedures, should strike through those procedures which they do not wish to request, initial, and date.

QUALIFICATIONS FOR PEDIATRIC HEMATOLOGY/MEDICAL ONCOLOGY

Education and training	Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in pediatrics, followed by successful completion of an accredited ACGME fellowship in pediatric hematology/medical oncology.
Certification	Current subspecialty certification or board eligible (with achievement of certification within seven (7) years of post-graduate training) leading to subspecialty certification in pediatric hematology/medical oncology, by the American Board of Pediatrics.
Required current experience – initial	Demonstrated current competence and evidence of the provision of pediatric hematology / medical oncology services, reflective of the scope of privileges requested, during the past 12 months, or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months
Required current experience – renewal	Demonstrated current competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and peer review outcomes as per the Medical Staff Bylaws.
Ability to perform (health status)	Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

Approved by MEC = May 11th, 2021

PEDIATRIC HEMATOLOGY/MEDICAL ONCOLOGY CLINICAL PRIVILEGES

Name: _____

Effective From ____/____/_____ To ____/____/_____

CORE PRIVILEGES – PEDIATRIC HEMATOLOGY/MEDICAL ONCOLOGY

Requested ☐ **BHMC** ☐ **BHCS**

Admit, evaluate, diagnose, consult and provide treatment to children and adolescents presenting with diseases and disorders of the blood and immune system and provide treatment or consultative services to children and adolescents with cancerous diseases. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures below and such other procedures that are extensions of the same techniques and skills.

1. Perform history and physical exam
2. Assessment of tumor imaging by review of computed tomography, magnetic resonance, PET scanning, and nuclear imaging
3. Complete blood count, including platelets and white cell differential, by means of automated or manual techniques
4. Diagnostic lumbar puncture with evaluation of cerebrospinal fluid
5. Interpret bone marrow biopsies
6. Lymph node aspiration
7. Management and maintenance of indwelling venous access catheters
8. Preparation, staining, and interpretation of peripheral blood smears
9. Performing bone marrow aspirates and touch preparations
10. Serial measurement of tumor masses

BHMC Only

1. Administration of chemotherapeutic agents and biological response modifiers through all therapeutic routes
2. Perform bone marrow biopsies
3. Therapeutic thoracentesis and paracentesis

SPECIAL NON-CORE PRIVILEGES (SEE SPECIFIC CRITERIA)

Non-Core Privileges are requested individually in addition to requesting the core. Each individual requesting Non-Core Privileges must meet the specific threshold criteria as applicable to the initial applicant or reapplicant.

Approved by MEC = May 11th, 2021

PEDIATRIC HEMATOLOGY/MEDICAL ONCOLOGY CLINICAL PRIVILEGES

Name: _____

Effective From ____/____/_____ To ____/____/_____

BONE MARROW TRANSPLANTATION

Requested **BHMC**

Criteria: Successful completion of an ACGME/AOA-accredited training program in medical oncology, hematology, or immunology followed by completion of a BMT fellowship program or a minimum of one year of clinical experience in a Foundation for the Accreditation of Cellular Therapy (FACT) accredited BMT program that included autologous and allogeneic transplantation. ***Required Current Experience:*** Demonstrated current competence and evidence of the performance of at least [n] BMT procedures in the past 12 months or completion of training in the past 12 months. These procedures must be in the BMT area (harvesting, autologous transplants, or allogeneic transplants) for which privileges are requested. ***Renewal of Privilege:*** Demonstrated current competence and evidence of the performance of at least [n] procedures reflective of the BMT area requested in the past 24 months based on results of ongoing professional practice evaluation and peer review outcomes.

- ☐ **Requested** High dose chemotherapy with autologous peripheral blood stem cell and/or bone marrow transplantation
- ☐ **Requested** Allogeneic bone marrow transplantation
- ☐ **Requested** Stem cell harvest

PEDIATRIC HEMATOLOGY/MEDICAL ONCOLOGY CLINICAL PRIVILEGES

Name: _____

Effective From ____/____/_____ To ____/____/_____

ACKNOWLEDGEMENT OF PRACTITIONER

Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at Broward Corporate, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed_____ ***Date***_____

DEPARTMENT CHAIRPERSON'S RECOMMENDATION

Check the appropriate box for recommendation.

If recommended with conditions or not recommended, provide explanation. *I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s)**:***

☐ Recommend all requested privileges.
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____

Notes

_____

_____

_____

Department Chairperson Signature_____ ***Date***_____

FOR MEDICAL STAFF SERVICES DEPARTMENT USE ONLY

Credentials Committee Action ***Date***_____
Medical Executive Committee Action ***Date***_____
Board of Commissioners Action ***Date***_____

BHMC = Broward Health Medical Center; BHCS = Broward Health Coral Springs;
BHIP = Broward Health Imperial Point; BH North = Broward Health North

Approved by MEC = May 11th, 2021