Surgical Privileges Form: Dermatology (Core Privileges)

Clinical Privileges Request

Applicant's Name: ..... Scope of Practice: .....

License No. (If Any): ..... Facility: .....

Date: .....

Privileges	Requested (To be completed by the applicant)	Recommended (For committee use)		Not Recommended (For committee use)
		Under Supervision	Independent	

Core Privileges

1. History taking, local skin examination and description of skin lesions with subsequent topical applications description.				
2. Dermojet				
3. Punch Biopsy				
4. Intralesional				
5. Curettage				
6. Comedone extraction				
7. Liquid nitrogen application (cryocautery)				
8. Skin Paring (warts/superficial keratosis/callosity				
9. Electrocautery				
10. Local Chemical cautery				
11. Removal of sutures				
12. Minor skin surgery (with local anesthesia)				
13. Laser therapy				
14. Chemical peeling				
15. DTM culture (fungus)				

Name of applicant: ----------

Privileges	Requested (To be completed by the applicant)	Recommended (For committee use)		Not Recommended (For committee use)
		Under Supervision	Independent	
16. KOH scrapings				
17. Methylin blue				
18. Botux injection				
19. Patch test				
20. Wood's light				
21. Crystal peel(Microdermabrasion)				
22. Dermal fillers				
23. PRP				

Note: You must submit along with this application all necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.

By signing below, I acknowledge that I have read, understand, and agree to abide by QCHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

a) In exercising any clinical privileges granted, I am constrained by QCHP's 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 recognized policies and rules.

…….. ……
Applicant's signature (Stamp if any) Date

1. …….. ……
Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signature Date

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For Committee use only

Evaluation Committee Chairman:

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and I have made the above-noted recommendation(s).

…….. ……
Chairperson's Stamp & signature Date

Other Committee Members:

…….. ……
1) Name Date

…….. ……
1) Name Date

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