LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN FAMILY MEDICINE

Initial ☐ **Renewed** ☐

Name_____ **Effective from** ___/___/___ **to** ___/___/___

R = Requested G = Recommended As Requested C = Recommended with Conditions N = Not Recommended

R	G	C	N	POPULATION
☐	☐	☐	☐	Pediatric: Birth - 25 Years (LVHN Surgery Center-Tilghman - 6 months - 1 Year and LVHN Children's Surgery Center - 6 months - 1 Year)
☐	☐	☐	☐	Adults: 13 - 65 Years
☐	☐	☐	☐	Geriatrics: Over 65 Years

R	G	C	N	GENERAL PRIVILEGES - ALL ACTIVE STAFF
☐	☐	☐	☐	Admitting Privileges (includes inpatient, outpatient procedures and observation)(REQUIRED FOR ALL)(1,2,3,5,6,7,8,10,11,13,19, 20)
☐	☐	☐	☐	Consultation Privileges (REQUIRED FOR ALL)(1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Consultation Privilege to accept Referrals as a Geriatrician (MUST be a Member of the Section of Geriatrics) (1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	History and Physical (REQUIRED FOR ALL)(1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Prescribing Privileges (REQUIRED FOR ALL)(1,2,3,5,6,7,8,10,11,13,19,20)
☐	☐	☐	☐	Certifying of Medical Marijuana* (1,2,3,5,6,7,8,9,10,11,13,19,20) (*Must satisfy certain credentialing criteria to be approved)

R	G	C	N	INPATIENT CARE
☐	☐	☐	☐	Inpatient Rounding - Newborn Nursery (*NRP and BLS required)
☐	☐	☐	☐	Inpatient Rounding - Pediatric Age Population (*PALS and BLS required)
☐	☐	☐	☐	Inpatient Rounding - Adult & Geriatric Age Population (*ACLS and BLS required)

R	G	C	N	GENERAL PROCEDURES
☐	☐	☐	☐	Administration of blood products and its derivatives - transfusions (1,2,3,7,10,11,13,19,20)
☐	☐	☐	☐	Arterial puncture (1,2,3,7,10,11,13,19,20)
☐	☐	☐	☐	Arthrocentesis (1,2,3,7,8,10,11,13,19,20)

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R	G	C	N	GENERAL PROCEDURES
☐	☐	☐	☐	Corticosteroid Injections (1,2,3,5,6,7,8,10,13,19,20)
☐	☐	☐	☐	Dermatologic procedures (1,2,3,7,8,10,11,13,19,20)
☐	☐	☐	☐	Diagnosis and treatment of medical or surgical conditions (1,2,3,7,8,10,11,13,19,20)
☐	☐	☐	☐	Lumbar puncture (1,2,3,7,8,10,11,13,19,20)
☐	☐	☐	☐	Manage patients in infusion centers (includes blood products and its derivatives, medications and IV fluids) (1,2,3,7,8,10,11,13,19,20)
☐	☐	☐	☐	Outpatient procedures (1,2,3,7,8,10,11,13,19,20)
☐	☐	☐	☐	Paracentesis - Abdominal (Inpatient only) (1,2,7,8,10,13,19,20)
☐	☐	☐	☐	Paracentesis - Thoracic (Inpatient only) (1,2,7,8,10,13,19,20)
☐	☐	☐	☐	POCUS-Inpatient *for all licensed sites that accept inpatients (1,2,3,5,6,7,8,9,10,11,13) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	POCUS-Musculoskeletal *for all licensed sites that accept inpatients (1,2,3,5,6,7,8,9,10,11,13) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Sigmoidoscopy - Flexible (1,2,3,7,8,10,13,19,20)
☐	☐	☐	☐	Treadmill stress test* (1,2,7,8,10,13,19,20) (*Must satisfy certain credentialing criteria to be approved)

R	G	C	N	BIRTHING PRACTICE *Must satisfy certain credentialing criteria to be approved
☐	☐	☐	☐	Amnio infusion* (1,2,7,10)
☐	☐	☐	☐	Amniotomy* (1,2,7,10)
☐	☐	☐	☐	Anesthesia - local block* (1,2,7,10)
☐	☐	☐	☐	Anesthesia - paracervical block* (1,2,7,10)
☐	☐	☐	☐	Anesthesia - pudenal block* (1,2,7,10)
☐	☐	☐	☐	Bio Physical Profile* (BPP) (1,2,7,8,10)
☐	☐	☐	☐	Cesarean section, classical or low cervical* (WITH OB CONSULTATION ONLY) (1,2,7,10,11)

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R	G	C	N	BIRTHING PRACTICE *Must satisfy certain credentialing criteria to be approved
☐	☐	☐	☐	Cesarean section, transverse* (1,2,7,10)
☐	☐	☐	☐	Dilation and Curettage (D & C), incomplete or missed abortion* (under 12 weeks) (1,2,3,7,8,9,10)
☐	☐	☐	☐	Episiotomy and repair* (1,2,7,10)
☐	☐	☐	☐	Evaluate and Interpret Diagnostic Obstetrical Ultrasound Examinations* (1,2,7,10) (*Must satisfy certian credentialing criteria to be approved)
☐	☐	☐	☐	Evaluate and Interpret Diagnostic Ultrasound Examinations of the Female Pelvis* (1,2,7,10) (*Must satisfy certian credentialing criteria to be approved)
☐	☐	☐	☐	Evaluate and Interpret Limited Diagnostic Obstetric Ultrasound Examinations* (1,2,7,10) (*Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Excision of vulvar or perineal lesions/Drainage of vulvar hematoma* (1,2,7,8,10)
☐	☐	☐	☐	First Assist - Cesarean section, classical or low cervical* (1,2,7,10)
☐	☐	☐	☐	Forceps* (at Cesarean Section) (1,2,7,10)
☐	☐	☐	☐	Hemorrhoid excision* (1,2,7,10)
☐	☐	☐	☐	Induction/augmentation of labor* (1,2,7,10)
☐	☐	☐	☐	Laceration repair, cervical* (1,2,7,10)
☐	☐	☐	☐	Laceration repair, perineal* (1,2,7,10)
☐	☐	☐	☐	Laceration repair, rectal sphincter only* (1,2,7,10)
☐	☐	☐	☐	Laceration repair, rectal sphincter with rectal mucosa with consult* (1,2,7,10)
☐	☐	☐	☐	Laceration repair, vaginal* (1,2,7,10)
☐	☐	☐	☐	Laminaria, insertion* (1,2,3,7,8,10)
☐	☐	☐	☐	Manual extraction of placenta* (1,2,7,10)
☐	☐	☐	☐	Manual replacement of inverted uterus* (emergency only - with consult) (1,2,7,10)
☐	☐	☐	☐	Placement of Intrauterine Pressure Catheter (IUPC)* (1,2,7,10)

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R	G	C	N	**BIRTHING PRACTICE *Must satisfy certain credentialing criteria to be approved**
☐	☐	☐	☐	Repair of laceration of external anal sphincter* (1,2,7,10)
☐	☐	☐	☐	Termination of pregnancy, 1st Trimester* (1,2,3,7,8,10)
☐	☐	☐	☐	Tocolysis with consult* (1,2,7,10)
☐	☐	☐	☐	Tubal ligation, postpartum via mini-laparotomy* (1,2,7,10)
☐	☐	☐	☐	Vacuum Extraction* (at Cesarean Section) (1,2,7,10)
☐	☐	☐	☐	Vaginal delivery, forceps, low or outlet* (1,2,7,10)
☐	☐	☐	☐	Vaginal delivery, vacuum extraction* (1,2,7,10)
☐	☐	☐	☐	Vaginal delivery, vertex, spontaneous* (1,2,7,10)

R	G	C	N	**CHILDREN AND ADOLESCENTS**
☐	☐	☐	☐	Attendance at Cesarean sections and newborn deliveries (1,2,7,10) (Requires certification in Neonatal Resuscitation)
☐	☐	☐	☐	Circumcision of male infants, gomco* (1,2,3,7,9,10) (Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Endotracheal intubation (1,2,7,10) (Requires certification in Neonatal Resuscitation)

R	G	C	N	**WOMEN'S HEALTH AND FAMILY PLANNING**
☐	☐	☐	☐	Bartholin cyst, incised and drained and/or marsupialization (1,2,3,7,8,10,13,19,20)
☐	☐	☐	☐	Cervix, biopsy during colposcopy (Must have colposcopy privileges) (1,2,3,7,8,10,13,19,20)
☐	☐	☐	☐	Colposcopy* (1,2,3,7,8,10,13,19,20) (Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Diaphragm fitting (1,2,3,7,8,10,13,19,20)
☐	☐	☐	☐	Endometrial biopsy (1,2,3,7,8,9,10,13,19,20)
☐	☐	☐	☐	Insertion of Intrauterine Device (IUD)* (1,2,3,7,8,9,10,13,19,20) (Must satisfy certain credentialing criteria to be approved)

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R	G	C	N	WOMEN'S HEALTH AND FAMILY PLANNING
☐	☐	☐	☐	Sonohysterography injection procedure (SIS) (In Hospital)
☐	☐	☐	☐	Nexplanon Removal* (1,2,3,7,8,10,13,19,20) (Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Pessary insertion (1,2,3,7,8,9,10,13,19,20)

R	G	C	N	OTHER
☐	☐	☐	☐	Acupuncture* (1,2,3,7,8,10,13,19,20) (Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Continuous-assisted ventilation - limited (1,2,3,7,8)
☐	☐	☐	☐	Office based spirometry* (1,2,3,5,6,7,8,10,11,13,19,20) (Must satisfy certain credentialing criteria to be approved)
☐	☐	☐	☐	Osteopathic manipulation (OMM) (1,2,3,5,6,7,8,10,11,13,19,20) (Allopathic certificate of training required)
☐	☐	☐	☐	Vasectomy* (1,2,3,7,8,10,11,13,19,20) (Must satisfy certain credentialing criteria to be approved)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN FAMILY MEDICINE

Name_____

Privileges by Location:

1 – LVH-Cedar Crest
2 – LVH-Muhlenberg (includes the Behavioral Health Center and Cancer Center)
3 – LVH-17th & Chew (includes TSU)
5 – LVH-Tilghman
6 – LVHN Surgery Center-Tilghman
7 – LVH-Hazleton
8 – Health and Wellness Center at Hazleton
9 - LVHN Children's Surgery Center
10 - LVH-Schuylkill East Norwegian
11 - LVH-Schuylkill South Jackson
13 - LVH-Hecktown Oaks
14 - LVH-Coordinated Health - Allentown
15 - LVH-Coordinated Health - Bethlehem
16 - LVHN Ambulatory Surgery Center of Lopatcong, Inc
17 - LVHN East Stroudsburg Ambulatory Surgery Center
18 - LVH-Pocono
19 - LVH-Carbon
20 - LVH-Dickson City

LEHIGH VALLEY HEALTH NETWORK

CLINICAL AREA FAMILY MEDICINE

Name_____

Acknowledgement of Practitioner

I hereby request the privileges noted.

Practitioner Signature:_____Date:_____/_____/_____

*****Recommendations*****

I have reviewed the request for clinical privileges and supporting documentation and

☐ **Recommend As Requested** ☐ **Recommend with Exceptions** ☐ **Do Not Recommend**

the privileges requested above.

EXCEPTIONS

Exception to Privilege:	Conditions/Modifications

Explanation:

SUPERVISING PHYSICIAN (AHPs ONLY) _____ _____/_____/_____

Title Signature Date

_____ _____ _____/_____/_____

Title Signature Date

_____ _____ _____/_____/_____

Title Signature Date

_____ _____ _____/_____/_____

Title Signature Date

_____ _____ _____/_____/_____

Title Signature Date