LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN INFECTIOUS DISEASES

Initial ☐ **Renewed** ☐

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

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

R	G	C	N	POPULATION
☐	☐	☐	☐	Adults: 13 - 65 Years
☐	☐	☐	☐	Geriatrics: Over 65 Years

R	G	C	N	GENERAL PRIVILEGES
☐	☐	☐	☐	Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Consultation Privileges (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	History and Physical (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Prescribing Privileges (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Certifying of Medical Marijuana (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12) (*Must satisfy certain credentialing criteria to be approved)

R	G	C	N	GENERAL PROCEDURES
☐	☐	☐	☐	Arthrocentesis (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Paracentesis (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Perform pelvic examinations and pap smears as indicated (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Lumbar Puncture (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Thoracentesis (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Wound Debridement (non-excisional) (1,2,3,4,5,6,7,8,10,11,12)

R	G	C	N	OTHER
☐	☐	☐	☐	Arterial Puncture (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Emergency Defibrillation (1,2,3,4,5,6,7,8,10,11,12)

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R	G	C	N	OTHER
☐	☐	☐	☐	Penicillin Skin Testing (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Pericardiocentesis - Emergency (1,2,3,4,5,6,7,8,10,11,12)
☐	☐	☐	☐	Skin Biopsy (1,2,3,4,5,6,7,8,10,11,12)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN INFECTIOUS DISEASES

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)
4 – Fairgrounds Surgical Center
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
12-LVH-Schuylkill Surgery Center

LEHIGH VALLEY HEALTH NETWORK

CLINICAL AREA INFECTIOUS DISEASES

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