LEHIGH VALLEY HEALTH NETWORK

CLINICAL PRIVILEGES IN DERMATOLOGY

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	NO CLINICAL PRIVILEGES
☐	☐	☐	☐	No Clinical Privileges

R	G	C	N	GENERAL PRIVILEGES
☐	☐	☐	☐	Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,4,5,6,7,8,10,11, 13)
☐	☐	☐	☐	Consultation Privileges (1,2,3,4,5,6,7,8,10,11,13)
☐	☐	☐	☐	History and Physical (1,2,3,4,5,6,7,8,10,11,13)
☐	☐	☐	☐	Prescribing Privileges (1,2,3,4,5,6,7,8,10,11,13)

R	G	C	N	GENERAL PROCEDURES
☐	☐	☐	☐	Cryosurgery (1,2,3,7,8,10,11,13)
☐	☐	☐	☐	Excisions (wide, narrow, punch) (1,2,3,7,8,10,11,13)
☐	☐	☐	☐	Intralesional injections (1,2,3,7,8,10,11,13)
☐	☐	☐	☐	Laser Therapy of Skin/Appendages* (1,2,3,8,10,11,13) (*Must satisfy certain credentialing criteria to be approved.)
☐	☐	☐	☐	Laser Treatment (1,2,3,7,8,10,11,13)
☐	☐	☐	☐	Punch and shave and incisional biopsies (1,2,3,7,8,10,11,13)
☐	☐	☐	☐	Shave removal (1,2,3,7,8,10,11,13)

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R	G	C	N	GENERAL PROCEDURES
☐	☐	☐	☐	Skin Biopsy (1,2,3,7,8,10,11,13)

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN DERMATOLOGY

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 DERMATOLOGY

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