SAN GORGONIO MEMORIAL HOSPITAL
PRIVILEGE DELINEATION LIST
PATHOLOGY

NAME OF APPLICANT:_____ DATE:_____

YEAR OF BOARD CERTIFICATION/RECERTIFICATION_____

PRIVILEGES CATEGORY	QUALIFICATIONS/CRITERIA
CATEGORY I	**USUAL AND CUSTOMARY PRIVILEGES** (Procedures considered included in minimal formal training.)
	QUALIFICATIONS: 1. Successful completion of an accredited Pathology residency training program, AND, 2. Board qualified/certified by the American Board of Pathology with specific training and recent experience in privileges requested, OR, (in lieu of Board Certification) 3. Demonstrate comparable competency to perform the privileges requested based on proctoring reports, reference letters, activity/operative reports or other documentation acceptable to the Surgical Service, AND have been practicing in Pathology for the past 5 years. 4. Privileges will be proctored per Surgical Service Rules and Regulations.
CATEGORY 2	**ADVANCED PRIVILEGES** (Procedures performed requiring special expertise and/or requiring documented special training and/or certification, when it exists)

CATEGORY 1 USUAL AND CUSTOMARY PRIVILEGES	REQUESTED	GRANTED
PATHOLOGIC ANATOMY		
Autopsies:		
1. Adult	_____	_____
2. Pediatric	_____	_____
BONE MARROW		
1. Aspirations, biopsy and associated local anesthesia	_____	_____
2. Interpretations	_____	_____
SURGICAL PATH		
1. Gross	_____	_____
2. Micro	_____	_____
3. Frozen Sections	_____	_____
TISSUE DEPARTMENT		
1. Direction & Supervision	_____	_____
PAP SMEARS & CELL BLOCKS		
1. Urine	_____	_____
2. Sputum Bronch Wash	_____	_____
3. Serous Fluids	_____	_____
4. Gastric	_____	_____
CLINICAL PATHOLOGY (Clinical & Pathologic Correlation & Consultation)		

1. Clinical Chemistry	_____	_____
2. Hematology	_____	_____
3. Immunohematology	_____	_____
4. Microbiology & Parasitology	_____	_____
5. Serology	_____	_____
6. Clinical Microscopy	_____	_____
WAIVE TESTING	_____	_____

STAFF CATEGORY REQUESTED: ☐ ACTIVE ☐ COURTESY ☐ CONSULTING

SIGNATURE OF APPLICANT: _____ DATE _____

APPROVALS:

Applicant may perform privileges and procedures as indicated: [ ]

Exceptions/Limitations:_____

I have reviewed the applicant's health status and can attest that there are no health problems that exists that could affect his or her ability to perform the privileges requested.

_____ _____
Chairman, Surgical Services Date

_____ _____
Chairman, Credentials Committee Date

_____ _____
Chairman, Medical Executive Committee Date

_____ _____
Chairman, Board of Directors Date