CLINICAL PHARMACIST
PRIVILEGE FORM

PRINT NAME: _____EFFECTIVE DATE: _____ to _____

The minimum education, training, and experience qualifications for core privileges are as delineated in each hospital's Medical Staff Bylaws, Rules and Regulations, or policies. Please consult these documents to determine your eligibility to request these privileges.

LEGEND: **1 – Baptist** **2 – Beaches** **3 – Nassau** **4 – St. Luke's** **5 – St. Vincent's** **6 - Shands/Jax** **7- Wolfson** **8 - Brooks** **9 - South**

To request Core Privileges, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	CORE PRIVILEGES	APPR
	■	■	■		■		■		Assessment of patient's medication regimen, including ordering of laboratory tests pursuant to quantitative evaluation of pharmacotherapeutic agents and placement of a written summary of findings/recommendations in the progress notes section of the patient medical record.	
	■	■	■		■		■		On the request of a licensed physician, with staff privileges at the respective institution, performance of a pharmacokinetic evaluation/consultation including ordering of appropriate laboratory tests and adjustment of drug dosage or administration regimen to achieve pre-determined concentrations of a pharmacotherapeutic agent in ora at the desired fluid, tissue or site.	

To request privileges, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	SPECIAL PROCEDURES Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training or experience.	APPR
	■	■	■		■		■		Performance of basic physical examinations including, but not limited to, blood pressure determination, heart rate, auscultation and spirometry pursuant to monitoring the therapeutic efficacy of medication.	
	■	■	■		■		■		Clinical drug research under a protocol approved by the hospital's institutional review committee.	

Acknowledgement of Practitioner: I understand that (a) in exercising clinical privileges granted, I am constrained by each hospital's Medical Staff Policies, rules and regulations, and (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 applicable section of each hospital's Medical Staff Bylaws.

***Applicant Signature:*_____ *Date:*_____**

■ If blacked out, this privilege is not available in this specialty at this hospital.
++ Please refer to this hospital's Bylaws or Rules and Regulations regarding specific criteria to be met before this privilege may be granted.

Edition date – 11/21/2011

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Acknowledgment of Supervising Physician: The above named practitioner shall be under my supervision (direct or indirect in accordance with the laws of the State of Florida) in the exercise of clinical privileges. I acknowledge that the above named practitioner is competent and qualified to perform the requested privileges.

Supervising Physician Signature: _____ ***Date:*** _____

Supervising Physician Signature: _____ ***Date:*** _____

Supervising Physician Signature: _____ ***Date:*** _____

Supervising Physician Signature: _____ ***Date:*** _____

Supervising Physician Signature: _____ ***Date:*** _____

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