

HEMATOLOGY/ONCOLOGY PRIVILEGE FORM

NAME: _____ **EFFECTIVE DATE:** _____ **To** _____

LEGEND: 1 – BMC - Jax 2 – BMC - Beaches 3 – BMC - Nassau 4 – SV Southside 5 – SV Riverside
6 – UF Health Jax/SJ TCU 7 – Wolfson 8 – Brooks 9 – BMC - South 10 – SV Clay

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.

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

1	2	3	4	5	6	7	8	9	10	INTERNAL MEDICINE CORE PRIVILEGES	APPR
										Work-up, admission, evaluation, history and physical examination, diagnosis, consultation and/or provision of non-surgical treatment to patients from adolescence to old age during times of health and through all stages of acute and chronic illness.	

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

1	2	3	4	5	6	7	8	9	10	HEMATOLOGY CORE PRIVILEGES	APPR
										Work-up, admission, evaluation, history and physical examination, diagnosis, and provision of treatment or consultative services to patients presenting with illnesses and disorders of the blood and blood forming tissues.	

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

1	2	3	4	5	6	7	8	9	10	ONCOLOGY CORE PRIVILEGES	APPR
										Work-up, admission, history and physical examination, diagnosis and provision of treatment or consultative services to patients with neoplastic diseases.	

To request Special Procedures, please place an "X" in the appropriate hospital column. If the condition/privilege you desire is not included on this form, please submit a separate written request along with appropriate documentation of training and/or experience.

1	2	3	4	5	6	7	8	9	10	SPECIAL PROCEDURES Procedures that may not be part of training, and may require proof of training or experience.	APPR
										Arterial cannulation	
										Cytopheresis	
										Intraperitoneal Therapy [++ Hospitals 2]	
										Intraleural Chemotherapy Administration	
										Moderate Sedation [++Hospitals 1, 2, 3, 4, 5, 6, 7, 9, 10]	

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:** _____

- Privilege 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.