

PEDIATRIC ANESTHESIOLOGY PRIVILEGE FORM

NAME: _____ EFFECTIVE DATE: _____ To _____

LEGEND: 1 – BMC Jax 2 – BMC - Beaches 3 – BMC-Nassau 4 – SV Southside 5 – SV Riverside
 6 - Shands Jax/SJ 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	CORE PRIVILEGES	APPR
										Medical management of pediatric patients who are rendered unconscious or insensible to pain and emotional stress during surgical and certain other medical procedures; the protection of life functions and vital organs; the management of problems in pain relief, cardiopulmonary resuscitation and pulmonary care. Including planning and management of preoperative care and postoperative management.	

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	APPR
										Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training or experience.	

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: _____

Acknowledgment of Supervising Physician: The above named practitioner shall be under my supervision in the exercise of clinical privileges. I acknowledge that above named practitioner is competent and qualified to perform the requested privileges.

Supervising Physician Signature: _____ Date: _____

Supervising Physician Signature: _____ Date: _____

Supervising Physician 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.