BAYLOR SCOTT & WHITE TEXAS SPINE & JOINT HOSPITAL
DELINEATION OF PRIVILEGES
INTERNAL MEDICINE

To be eligible to request clinical privileges in internal medicine, an applicant must meet the following minimum threshold criteria:

- Basic education: MD *or* DO
- Minimum formal training: Successful completion of an ACGME-or-AOA-accredited residency in internal medicine.
- Core privileges in internal medicine: Admit, evaluate, diagnose, treat, and provide consultation to patients 13 years if age or older with common and complex illnesses, diseases, and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, and genitor-urinary systems. (The physician may provide care to patients in the intensive care setting in conformance with unit policies.) Internal Medicine physician's access, stabilizes, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Core privileges include but are not limited to:

REQUESTED	PROCEDURE	APPROVED	DENIED
	Abdominal paracentesis		
	Arthrocentesis and joint injections		
	Breast cyst aspirations		
	Burns, superficial and partial thickness		
	Chronic ventilator management		
	Excision of skin and subcutaneous tumor, nodules, and lesions		
	I and D abscess		
	Insertion and management of central venous catheters, and arterial lines		
	Local anesthetic techniques		
	Performance of simple skin biopsy an excision		
	Performance of history and physical exam		
	Placement of anterior and posterior nasal hemostatic packing		
	Interpretation of electrocardiograms		
	Removal of nonpenetrating corneal foreign body, nasal foreign body		
	Suprapubic bladder aspiration		
	Thoracentesis		
	Venous cutdown		

- **Reappointment:** Reappointment should be based on unbiased, objective results of care, according to the organization's quality assurance mechanisms.

I understand that by making this request, I am bound by the applicable bylaws or policies of the hospital and hereby stipulate that I meet the minimum threshold criteria for this request.

Physician's signature: _____

Printed name: _____

Date: _____