DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED
OMB Approval No. 0917–0009
Expiration Date: 06/30/16

PATHOLOGY PRIVILEGES REQUEST FORM

INTRODUCTION

The Pathology Privileges Request Form must be accompanied or preceded by a complete application for medical staff appointment, including the necessary supporting documents. Many clinical privileges pertinent to the practice of pathology are listed below. The request for privileges must reflect both the applicant's and the facility's/staff's ability to carry out or support the various functions. Documentation of training and/or experience in performing various procedures/modalities must accompany this request. Any additional privileges may be requested on the form or may be presented in an attached list.

INSTRUCTIONS FOR COMPLETING THE FORM

Applicant: With a check mark in the appropriate location, indicate for each item whether you are requesting *limited* or *full* privileges. *Limited* means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding *full* privileges. *Full* means that the applicant is entitled to function independently, following standards consistent with the medical community at large. Be sure to sign the request as indicated on page 3.

Discipline-specific supervisor or consultant: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either *full, limited,* or *not recommended* (N.R.). Please explain any recommended limitations or denial of privileges on an attached sheet. This recommendation is considered by the governing body when granting or not granting privileges.

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
1. Autopsies: non-forensic	☐	☐	☐	☐	☐
2. Intraoperative surgical pathology	☐	☐	☐	☐	☐
3. Surgical pathology: microscopic examination, gross examination, and diagnosis with report	☐	☐	☐	☐	☐
4. Cytology: microscopic examination and diagnosis, with report	☐	☐	☐	☐	☐
5. Fine needle aspiration and biopsy: microscopic examination and diagnosis, with report	☐	☐	☐	☐	☐
6. Bone marrow aspirate and biopsy: microscopic examination and diagnosis, with report	☐	☐	☐	☐	☐
7. Muscle biopsy: light microscopic examination, and diagnosis, with report	☐	☐	☐	☐	☐
8. Muscle biopsy: light microscopic immuno-cytochemistry and for electron microscopic examination and diagnosis, with report	☐	☐	☐	☐	☐
9. Renal biopsy: light microscopic exam and diagnosis, with report	☐	☐	☐	☐	☐
10. Renal biopsy: light microscopic, electron microscopic, immunocytochemistry examination and diagnosis, with report	☐	☐	☐	☐	☐
11. Neuropathology: light microscopic exam and diagnosis, with report	☐	☐	☐	☐	☐
12. Cytogenetic studies on tissues	☐	☐	☐	☐	☐
13. Forensic pathology	☐	☐	☐	☐	☐
14. Open lung biopsy: light microscopic exam and diagnosis with report	☐	☐	☐	☐	☐
15. Open lung biopsy: light microscopic, electron microscopic and/or immunocytochemistry examination and diagnosis	☐	☐	☐	☐	☐

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
with report					
16. Hematology and coagulation	☐	☐	☐	☐	☐
17. Immunohematology consultation	☐	☐	☐	☐	☐
18. Clinical chemistry consultation	☐	☐	☐	☐	☐
19. Medical microbiology and parasitology consultation	☐	☐	☐	☐	☐
20. Medical microscopy consultation	☐	☐	☐	☐	☐
21. Serology and general immunology consultation	☐	☐	☐	☐	☐

PATHOLOGY PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

   _____ _____
   Applicant Date

2. I hereby recommend the clinical privileges as indicated.

   _____ _____
   Supervisor/Consultant Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (check one)

   ____ As noted.

   ____ With the following exceptions, deletions, additions, or conditions:

   _____

   _____ _____
   Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

   _____ _____
   Service Unit Director Date

5. Privileges are hereby granted: (check one)

   ____ As noted.

   ____ With the following exceptions, deletions, additions, or conditions:

   _____

   _____ _____
   Chairperson of the Governing Body Date

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 20 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Reports Clearance Officer, Indian Health Service, 801 Thompson Avenue, TMP Suite 450, Rockville, MD 20852, ATTN: PRA (0917–0009). Please *do not send* this form to this address.