Name:  
Effective Dates: __________  To: __________

☐ Initial privileges (initial appointment)  
☐ Renewal of privileges (reappointment)  
☐ Expansion of privileges (modification)

INSTRUCTIONS
All new applicants must meet the following requirements as approved by the UNM SRMC Board of Directors effective: 03/21/2012

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, current clinical activity, and other qualifications, and for resolving any doubts related to qualifications for requested privileges.

Clinical Service Chief: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other requirements:
Note that privileges granted may be exercised only at UNM SRMC and in setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.

This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.
To be eligible to apply for core privileges in Hematology, the initial applicant must meet the following criteria:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)–accredited residency in internal medicine followed by successful completion of an accredited fellowship in Hematology.

AND

Current subspecialty certification or active participation in the examination process with achievement of certification within 3 years leading to subspecialty certification in Hematology by the American Board of Internal Medicine or achievement of a certificate of added qualifications in Hematology by the American Osteopathic Board of Internal Medicine.

Notwithstanding the foregoing, applicants for clinical privileges may seek an exception to this Board Certification requirement under Section 2.004 of the Bylaws of the Medical Staff of UNM Sandoval Regional Medical Center (the "Medical Staff Bylaws") and may be granted clinical privileges if such applicant is determined, in accordance with Section 2.004 of the Medical Staff Bylaws, to have qualified for one or more of these exceptions.

Required previous experience: Applicants for initial appointment must be able to demonstrate the provision of rheumatologic inpatient, outpatient, or consultative services, reflective of the scope of privileges requested, or demonstrate successful completion of an ACGME- or AOA-accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

Reappointment requirements: To be eligible to renew core privileges in Hematology, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience (inpatient, outpatient, or consultative services) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on the results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.
Privileges to admit, evaluate, diagnose, and treat or provide consultative services to patients except where specifically excluded from practice except for those special procedure privileges listed below—with illness and disorders of the blood, blood-forming tissues or immunologic system.

- Requested

SPECIAL NON CORE PRIVILEGES (See Specific Criteria)

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence.

<table>
<thead>
<tr>
<th>Administration of Sedation and Analgesia privileges</th>
</tr>
</thead>
<tbody>
<tr>
<td>See hospital policy for sedation and analgesia by non-anesthesiologists.</td>
</tr>
<tr>
<td>☐ Check here to request Moderate Sedation privileges form (Separate form)</td>
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</tbody>
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<thead>
<tr>
<th>Internal Medicine Privilege</th>
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<tr>
<td>☐ Check here to request Internal Medicine privileges form (Separate form)</td>
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<tr>
<th>Limited Ultrasound for Guided Procedure</th>
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<tbody>
<tr>
<td>☐ Check here to request Limited Ultrasound Guided Procedure privileges form (Separate form)</td>
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</table>
This list is a sampling of procedures included in the core. It is not intended to be an all-encompassing list, but rather is reflective of the categories/types of procedures included in the core.

To the applicant: If you wish to exclude any procedures, please strike through those you do not wish to request, then initial and date.

☐ Requested

Core Procedures Hematology

1. bone marrow aspirations and biopsy
2. administration of chemotherapy
3. management and care of indwelling venous catheters
4. plasmapheresis
5. lymph node aspiration
6. therapeutic thoracentesis
7. paracentesis
Acknowledgment of Practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at UNM SRMC, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
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 the medical staff bylaws or related documents.

Signed ____________________________________ Date _____________________

Clinical Service Chief's Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges.
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

<table>
<thead>
<tr>
<th>Privilege</th>
<th>Condition/Modification/Explanation</th>
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<tbody>
<tr>
<td>1._________________</td>
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<td>2._________________</td>
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<td>4._________________</td>
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Notes:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Print Name ........................................... Signature ...................................... Date

Clinical Service Chief or Designee Signature