

**TEXAS SPINE & JOINT HOSPITAL**

**DELINEATION OF PRIVILEGES  
EMERGENCY MEDICINE**

**NAME:** \_\_\_\_\_

**INITIAL APPOINTMENT/REAPPOINTMENT  
(CIRCLE ONE)**

REQUESTED	PRIVILEGE	APPROVED	DENIED
	Local anesthetic and blocking procedures (No general anesthesia is to be administered in the ER)		
	<b>Conscious Sedation (SEE ATTACHED CRITERIA AND APPLICATION)</b>		
	<b>Deep Sedation</b>		
	<b>EKG Interpretation</b>		
	Emergency assessment and treatment of dermatologic conditions.		
	Emergency assessment and treatment of psychiatric and neurological conditions.		
	Emergency assessment and treatment of obstetrical and gynecologic conditions.		
	Emergency assessment and treatment of general pediatric conditions.		
	Emergency evaluation of X-rays needed in the initial assessment of medical or surgical conditions.		
	Emergency evaluation of and treatment of internal medicine conditions.		
	Emergency assessment and treatment of general surgical conditions, including general surgical and vascular techniques as needed for cardiopulmonary resuscitation.		
	Emergency assessment and treatment of ophthalmologic conditions.		
	Emergency assessment and treatment of orthopedic conditions.		
	Emergency assessment and treatment of otolaryngological conditions.		
	Emergency assessment and treatment of oral surgical conditions.		
	Emergency assessment and treatment of plastic surgery conditions.		
	Emergency assessment and treatment of urological conditions.		
	Emergency assessment and treatment of thoracic surgery conditions.		
	Emergency assessment and treatment of traumatic injuries.		

**Acknowledgment of Practitioner**

I am qualified to perform the privileges I have requested based on my licensure, education, training, experience and current competence. I certify that I am able to perform the privileges I have requested.

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Date

**The application for staff membership, including references/evaluations, and requested clinical privileges have been reviewed by:**

\_\_\_\_\_  
Section Chairman

\_\_\_\_\_  
Date

\_\_\_\_\_  
Department Chairman

\_\_\_\_\_  
Date

**Recommendation:**

Approved    Denied    Deferred

\_\_\_\_\_

Approved    Denied    Deferred

\_\_\_\_\_

**CRITERIA FOR  
EMERGENCY MEDICINE PHYSICIANS**

**EMERGENCY RESOURCES**

<b>Location: S. Broadway ER</b>	<b>ATLS</b>	<b>ACLS</b>
Board Certified in EM	N/A	N/A
Not Board Certified in EM	N/A	<b>Must Be Current</b>

**NOTE:**

**ALL PHYSICIANS requesting Conscious Sedation Privileges must provide documentation of at least 10 patients who have received Conscious Sedation within the past 24 months under their direction and must have current ACLS certification. (See Criteria and Application for Conscious Sedation Privilege Form).**