

UNIVERSITY OF MARYLAND MEDICAL CENTER MIDTOWN CAMPUS

Oncology

Delineation of Privilege Form

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Name: _____

Date: _____

Privilege / Operative Procedure	Applicant Check (√) if requested	Department Chief (Initial)		
		Recommended	Not Recommended	Hold in Abeyance (provide explanation)
Category I Privileges				
Admit and treat and / or consult on the medical needs of adolescent and adult patients				
ICU/CCU privileges for the admission, treatment and/or consultation of the medical needs of the patient				
Outpatient management of the medical needs of adolescent and adult patients				
Core procedures to include drawing venous and arterial blood, pap smear and endocervical culture; placement of peripheral venous line				
Interpretation of EKGs, chest x-rays and other plain x-rays				
Ventilator management < 48 hours				
Category II Privileges – Require successful completion of an approved recognized course when such exists, acceptable supervised residency or other acceptable advanced training				
Moderate Sedation- Criteria for Approval: must be competent in airway management				
Other Procedures: provide evidence of current competence for each of the following procedures:				
Arthrocentesis				
Central venous line placement				
Paracentesis				
Thoracentesis				
Lumbar puncture				
Nasogastric intubation				
Incision and drainage of abscess				

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		Recommended	Not Recommended	Hold in Abeyance (provide explanation)
Category II Privileges: Oncology				
Consult and treat on the condition / problem requiring skills or knowledge obtained at the level of subspecialty training in oncology				
Diagnosis and management of diseases of solid tumors, blood-forming organs and lymphatic tissue				
Chemotherapy, local, intra-arterial				
Chemotherapy, local, intraperitoneal				
Chemotherapy, systemic, for solid tumors				
Intrathecal chemotherapy				
Bone marrow biopsy and aspiration				

Acknowledgment of Practitioner:

I have requested only those specific privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform and for which I wish to exercise at UMMC Midtown and I understand that in exercising any clinical privileges granted, I am constrained by all UMMC Midtown and medical staff policies and rules applicable generally and all applicable to the particular situation.

Applicant's Signature

Date