

UNIVERSITY OF MARYLAND MEDICAL CENTER MIDTOWN CAMPUS

Pain Management

Delineation of Privilege Form

Name: _____

Date: _____

Privilege / Operative Procedure	Applicant Check (√) if requested	Department Chief (Initial)		
		Recommended	Not Recommended	Conditions (provide explanation)
Category I Privileges				
Admit, treat and / or consult on diseases / disorders / conditions causing pain.				
ICU/CCU privileges for the admission, treatment and/or consultation of the pain management needs of the patient.				
Management of problems in pain relief, using patient controlled analgesia (PCA)				
Administration of peripheral nerve blocks				
Muscle, bursa, tendon injections				
Category II Privileges – Require successful completion of a fellowship in Pain Medicine and / or acceptable supervised advanced training				
Facet joint injections; diagnostic and therapeutic- cervical, thoracic and lumbar				
Nerve blocks with neurolytic materials/ radiofrequency- cervical, thoracic and lumbar				
Sympathetic nerve blocks				
Epidural injections- cervical, thoracic, lumbar and caudal				
Insertion of epidural and intrathecal catheters, temporary				
Insertion / revision of permanent epidural and spinal catheters				
Insertion / replacement of percutaneous spinal cord stimulators				
Insertion / replacement of spinal cord stimulator batteries				
Insertion / replacement of implanted spinal pumps				
Percutaneous disc treatments				
Spinal lysis of adhesions				
Epidural / spinal endoscopy				

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		Recommended	Not Recommended	Conditions (provide explanation)
Category II Privileges continued				
Cervical discography				
Lumbar provocative discography				
Nerve root blocks				
Botox injections				
Joint injections				
Transforaminal Epidural Steroid injections (TFE)				
Fluoroscopy- for those who perform cases where fluoroscopy is used Evidence of current competency on initial application and completion of HealthStream fluoroscopy course every 2 years				

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 Campus. I understand that in exercising any clinical privileges granted, I am constrained by all UMMC Midtown Campus medical staff policies and rules applicable generally and all applicable to the particular situation.

Applicant's Signature

Date