

PACIFIC HOSPITAL OF LONG BEACH
DELINEATION OF PRIVILEGES
Department of Medicine/Family Practice
Dermatology

Name of Applicant: _____

Board Certification: _____ Year of Certification: _____

Subspecialty: _____ Year of Certification: _____

QUALIFICATIONS/CRITERIA	
Category I	<i>Usual and Customary Privileges</i>
	<ol style="list-style-type: none"> 1. Complete an ACGME or AOA accredited residency in Dermatology. 2. Board certification or qualification for certification by the American Board of Dermatology or AOA equivalent 3. Demonstrated competence in Category I privileges.
Category II	<i>Advanced Privileges - Procedures performed requiring special expertise and/or requiring documented special training and/or certification when it exists</i>
	<ol style="list-style-type: none"> 1. Board certification or in process of certification by the American Board of Dermatology. 2. Requires documentation of ability to perform the procedure(s) as outlined below: <ul style="list-style-type: none"> • Documentation of residency training and experience in the advanced procedure <li style="text-align: center;">OR • Additional fellowship training and certification by a training director with experience and demonstrated competence in the procedure requested. 3. Asterisked (*) procedures are high-risk, problem-prone which require specific training requirements.

Name: _____

Pacific Hospital of Long Beach <i>Dermatology privilege form</i>			
Requested	Usual and Customary Privileges	Granted	Special Conditions
	Category I		
	Condition requiring routine excision/drainage of cysts/routine biopsies		
	Dyshidrosis		
	Herpes Simplex and Zoster		
	Neurodermatitis		
	Nummular Dermatitis		
	Obvious drug eruption		
	Pediculosis		
	Scabies		
	Uncomplicated Acne Vulgaris		
	Uncomplicated Vial Exanthems		
	Verrucae		
	Uncomplicated actinic Keratoses		
	Uncomplicated basal cell and squamous cell carcinomas		
	Uncomplicated psoriasis		
	Category II		
	All dermatologic conditions		
	Chemical face peels		
	Dermabrasions		
	Hair transplants		
	Lip shaves		
	Lip wedges		
	Pinch, split and full thickness grafts		
	Routine biopsy or excision relating to a dermatology problem		

Signature of Applicant

Date

APPROVALS:

Exceptions/limitations: _____

Service Chief/Division Chief of Medicine/Family Practice

Date

Credentials Committee approval on: _____

Medical Executive Committee approved on: _____

Board of Directors approved on: _____

Name: _____