

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

Name of Applicant: \_\_\_\_\_

Board Certification: \_\_\_\_\_ Year of Certification: \_\_\_\_\_

Subspecialty: \_\_\_\_\_ Year of Certification: \_\_\_\_\_

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

Name: \_\_\_\_\_

<b>Pacific Hospital of Long Beach</b> <i>Neurology privilege form</i>			
<b><i>Requested</i></b>	<b><i>Usual and Customary Privileges</i></b>	<b><i>Granted</i></b>	<b><i>Special Conditions</i></b>
	Electroencephalography		
	Electromyography and Nerve Conduction Velocities		
	Lumbar puncture		
	Neurological consultation (Child)		
	Neurological consultation (Adult)		
	Neurological Evaluation and Treatment (Child)		
	Neurological Evaluation and Treatment (Adult)		
	Somatosensory Evoked Responses		
	Visual Evoked Responses		
	Brain Stem Auditory Evoked Responses		

\_\_\_\_\_  
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: \_\_\_\_\_