CMH REGIONAL HEALTH SYSTEM
Clinton Memorial Hospital
Wilmington, Ohio

PAIN MEDICINE PRIVILEGES

NAME: _____

QUALIFICIATIONS:

1. M.D., D.O.
2. Successful completion of an ACGME- or AOA accredited residency in anesthesiology, neurosurgery, neurology, psychiatry, or physical medicine and rehabilitation followed by successful completion of an ACGME approved Pain Fellowship or pain management experience of at least two years practicing pain management.
3. Current certification or active participation in the examination process leading to certification in pain medicine by the American Board of Anesthesiology, the American Osteopathic Board of Anesthesiology, the American Board of Neurological Surgery, the American Board of Psychiatry & Neurology, the American Board of Physical Medicine & Rehabilitation, or the American Board of Pain Management, or attain certification with the appropriate board within three years of completion of formal training. Initial board certification should in all cases occur within five years of completion of formal training in accordance with the respective board.
4. Applicants must be able to demonstrate the provision of inpatient, outpatient, or consultative pain medicine services, reflective of the scope of privileges requested for at least 50 patients during the previous 24 months. Applicants have ethe burden of producing information deemed adequate for proper evaluation of current competence.
5. INITIAL APPOINTMENT: Proof of completion of a 2-hr fluoroscopy training program approved by Clinton Memorial Hospital's (CMH) designated radiation expert, site-specific fluoroscopy training (provided by CMH), and radiation safety training (provided by CMH) is required.

PRIVILEGES INCLUDED IN THE CORE:

Admit, evaluate, diagnose, treat, and provide consultation to patients of all ages with acute and chronic pain that requires invasive pain medicine procedures beyond basic pain medicine. The core procedures include, but are not limited, to: Epidural injections; epidural, subarachnoid or peripheral neurolysis; Fluoroscopically guided facet blocks, sacroiliac joint injections and nerve root specific; implantation of subcutaneous, epidural, and intrathecal catheters; infusion port and pump implantation; injection of joint and bursa; percutaneous placement and implantation of neurostimulator electrodes; peripheral, cranial, costal, plexus, and ganglion nerve blocks; subcutaneous implantation of neurostimulator pulse generator; trigger point injection; chemical neuromuscular denervation (Botox injection); management of chronic headaches; chemical and radiofrequency modalities; superficial electrical stimulation techniques.

EXCLUSION: this clinical privilege request does not involve the practice of anesthesiology, neurology, or physiatry.

☐ Requested	☐ Recommended	☐ Not Recommended
☐ Recommended with the following modification(s) and reason(s):		

SPECIAL REQUEST PRIVILEGES

To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure.

Procedure	Criteria	Requested	Recommended	Not Recommended
Administration of Conscious Sedation	Meet criteria outlined in CSPP 2.053 (ex: ACLS or complete competency test provided by the CMH Medical Staff Office with a passing score of 80% or better.)	☐	☐	☐

ACKNOWLEDGMENT OF APPLICANT

I attest that I have read and understand the information contained within this Delineation of Clinical Privileges. I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Clinton Memorial Hospital, and;

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

I understand any restriction on the clinical privileges granted to me is waived in an emergency situation / urgent care of a critically ill patients and in such a situation the applicable section of the medical staff bylaws or related documents governs my actions.

_____ _____

Signature-Applicant Date

DEPARTMENT CHAIRS RECOMMENDATION:

I have reviewed the requested clinical privileges and supportive documentation for the above-named applicant and recommend action on the privileges as note above.

_____ _____

Signature-Department Director Medicine Date