MIDLAND MEMORIAL HOSPITAL
Delineation of Privileges
SLEEP MEDICINE

Your home for healthcare

Physician Name: _____

Sleep Medicine Core Privileges

Qualifications

Minimum threshold criteria for requesting core privileges in sleep medicine:

- Basic education: MD or DO
- Successful completion of an AASM or ACGME-accredited postgraduate training program in sleep medicine.

AND

- Current subspecialty certification or active participation in the examination process (with achievement of certification within 5 years) leading to subspecialty certification in sleep medicine by the relevant American Board of Internal Medicine, Family Medicine, Psychiatry and Neurology, or Pediatrics. Current certification by the ABSM is acceptable for applicants who became certified prior to 2007. *(*Members of the Staff prior to the adoption of Bylaws 10/2007 are considered grandfathered in and are encouraged but not required to achieve board certification).*

Required previous experience:

- Applicants for initial appointment must be able to demonstrate the evaluation, reflective of the scope of privileges requested, for at least 25 patients in the previous 12 months or demonstrate successful completion of an accredited postgraduate training program in the previous 12 months. Of those, 25 patients should carry a sleep disorder other than sleep-disordered breathing, such as insomnia, parasomnias, narcolepsy, and other disorders of excessive daytime sleepiness or the applicant must demonstrate successful completion of an accredited residency, clinical fellowship, or research in a clinical setting within the previous 12 months.

References for New Applicants

A letter of reference must come from the director of the applicant's sleep medicine training program. Alternatively, a letter of reference regarding competence should come from the chief of sleep medicine at the institution where the applicant most recently practiced.

Reappointment

Reappointment should be based on unbiased, objective results of care according to the organization's existing quality improvement measures. Applicants must demonstrate that they have maintained competence by showing evidence of the successful provision of sleep medicine services for at least 50 patients annually over the reappointment cycle based on the results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges

Please check requested privileges.

<table>
<tr><th>Requested ❑</th><th>Approved ❑</th><th>Not Approved ❑</th><td rowspan="2">Core privileges include but are not limited to:
Actigraphy
Home/ambulatory testing
Maintenance of wakefulness testing
Monitoring with interpretation of EKG, EEG, EOG, EMG+,
Flow, O2 saturation, leg movements, thoracic and abdominal movement, CPAP/BiPAP titration
Multiple sleep latency testing
Oximetry
Performance of history and physical exams
Administration of polysomnograms (including sleep stage scoring)
Sleep log interpretation</td></tr>
<tr><td colspan="3">Core Privileges: Core privileges in sleep medicine include the ability to admit, evaluate, diagnose, provide consultation, and treat patients of all ages presenting with conditions or disorders of sleep (e.g., sleep-disordered breathing, circadian rhythm disorders, insomnia, parasomnias, narcolepsy, and restless leg syndrome). Practitioners in this specialty may provide care to patients in the intensive care setting in conformity with unit policies.</td></tr>
<tr><th>Requested ❑</th><th>Approved ❑</th><th>Not Approved ❑</th><th>Criteria</th></tr>
</table>

<table>
<tr><td colspan="3">Refer-and-follow privileges</td><td>Privileges include performing outpatient preadmission history and physical, ordering noninvasive outpatient diagnostic tests and services, visiting patients in the hospital, reviewing medical records, consulting with the attending physician, and observing diagnostic or surgical procedures with the approval of the attending physician or surgeon.</td></tr>
<tr><td>Requested ❑</td><td>Approved ❑</td><td>Not Approved ❑</td><td>Privilege/Criteria</td></tr>
<tr><td colspan="3" rowspan="2">Current Privileges: List any current privileges not listed above in core or non-core. These privileges will remain in effect until the end of the current appointment period and then will be moved up to the appropriate core/non-core section.

Please provide criteria and supporting documentation to medical staff office for any non-core privileges listed.</td><td>Core
❑ _____
❑ _____
❑ _____
❑ _____</td></tr>
<tr><td>Non-Core
❑ _____
❑ _____
❑ _____
❑ _____</td></tr>
</table>

To the applicant: If you wish to exclude any privileges, please strike through the privileges that you do not wish to request and then initial.

I understand that by making this request, I am bound by the applicable bylaws or policies of the hospital, and hereby stipulate that I meet the minimum threshold criteria for this request. I have requested **only** those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Midland Memorial Hospital. I also acknowledge that my professional malpractice insurance extends to all privileges I have requested and I understand that:

(a) 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.

(b) Applicants have the burden of producing information deemed adequate by Midland Memorial Hospital for a proper evaluation of current competence, other qualifications and for resolving any doubts.

(c) I will request consultation if a patient needs service beyond my expertise.

_____ _____

Physician's Signature/Printed Name Date

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

❑ Recommend all requested privileges

❑ Recommend privileges with the following conditions/modifications:

❑ Do not recommend the following requested privileges:

Privilege Condition/modification/explanation

Notes:

_____

_____

_____ _____

Department Chair/Chief Signature Date