

**REQUEST FOR NEW PROCEDURE OR TREATMENT
AT TAHOE FOREST HOSPITAL DISTRICT**

(Note that NO FDA approved experimental treatment or drug therapies are permitted at TFHD)

To be completed by requesting physician (may be typed or clearly handwritten)

1. Name of requesting physician/date: _____
2. New privilege to be considered: _____
3. SETTINGS - Note the care setting(s) within the hospital system where this privilege can be performed (include one or both hospitals in this description)

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4. DESCRIPTION - Describe the procedure or treatment, including the indications and contraindications

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5. EQUIPMENT - List any new equipment required, or circle **NA**

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6. ADDITIONAL RESOURCES - List any additional resources required, or circle **NA**

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7. HOSPITAL STAFF - List any training required for hospital staff, or circle **NA**
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8. OUTCOME DATA- Describe any results, complications and/or other pertinent information reported in relevant scientific literature, with citations or attachments as appropriate.

9. TRAINING - Describe background and training required for qualifications to apply for this privilege (include any manufacturer guidelines, requirements and/or scientific literature and other sources of guidance as applicable). Check the following that apply

- Includes: hands on training didactic course proctoring
 special certification board certification
 demonstration of previous performance (supervised, numbers performed, outcome)

10. PREVIOUS EXPERIENCE – List any previous organization/s where you had this privilege

Name/Mailing Address/Contact Phone Number:

11. PROCTORING - Describe proposed proctoring or required proctoring (by some equipment manufacturers) to verify competence once practitioners are granted privileges to perform the new procedure or treatment; e.g., number of cases to be observed, retrospective review, etc. – please specify).

12. REAPPOINTMENT – Describe any requirements for privileging at reappointment that should be considered; e.g., minimum number to maintain competence over the past two years, CME, other

13. MONITORING/PERFORMANCE REVIEW – Describe review plan to assess overall experience once implemented for evaluation of anticipated results, comparative data, and other relevant factors, including attaching any relative literature.

To be completed by the Hospital Department Director

- 1. Can this privilege be performed within the scope of services provided by the organization? YES NO
- 2. Does the organization have or commit to the equipment and supplies necessary to support the privilege? YES NO
- 3. Does the organization have or commit to the appropriate # of qualified staff to support privilege? YES NO
- 4. Have the cost benefit analysis been completed and/or necessary financial resources been committed to support this privilege YES NO
- 5. Is Administration aware of proposed privilege/service and supportive of implementation? YES NO

Date service is expected to be implemented: _____

If any of above answers is "NO," please explain below

NAME/SIGNATURE: _____ DATE: _____

To be completed by Medical Staff Department Chair

Determination:

_____ Considered part of existing privilege not necessary to add to privilege listing.

If checked, part of what existing privilege: _____

_____ GENERAL privilege to be added to "Basic" privilege list which does not require additional training/education

_____ SPECIAL privilege (to be added as "Special Privilege" with defined criteria

_____ defined above _____ and/or the following:

Check one:

_____ I have reviewed all of the information for this privilege request, done any additional inquiries necessary, agree with the requirements stated with/without additional recommended criteria defined below and recommend approval of the privilege requested.

_____ I have reviewed all of the information for this privilege request, done any additional inquiries necessary, reviewed the requirements stated and **DO NOT** recommend approval of the privilege requested.

Reason for non-recommendation: _____

Signature: _____ Date: _____

Medical Executive Committee Action: _____ **Date:** _____

Board of Directors Action: _____ **Date:** _____

Medical Staff Services Action:

Incorporated into privilege listing: Date _____

Notified appropriate parties of action: Date _____