Community Hospitals and Wellness Centers
CHWC Montpelier Hospital (CAH)
CHWC Bryan Hospital
CHWC Archbold Hospital

MEDICAL STAFF SERVICES POLICY & PROCEDURE

SUBJ: MODIFICATION OF PRIVILEGES AND/OR CHANGE IN STAFF STATUS

DATE ISSUED: 05/09

REVISED: 7/21

REVIEWED: 10/11, 10/13, 10/15, 4/18, 7/18

POLICY NUMBER: **MD0003**

I. POLICY

A. A medical staff member may request a change in medical staff status or modification of clinical privileges upon written request.

II. PROCEDURE

A. Practitioners requesting a modification of privileges or a change in staff status must submit the request in writing or may complete the Modification of Privileges Request Form (Attachment 1) or the Change in Staff Status Form (Attachment 2) to the Medical Staff Office for processing. The request for these changes must meet criteria and the request for modification of privileges must include documentation supporting the request, i.e., evidence of appropriate training, experience and competency.

B. Requests shall not be acted upon if criteria and/or documentation requirements are not met, and such will not be considered a denial of change of status or granting of the privileges.

C. Privilege requests may be resubmitted at any time with inclusion of required documentation of training, experience and competency.

Approval:
Credential/Bylaws Committee: 07/21
Medical Staff: 08/21
Board of Directors: 08/21

(Attachment 1)

Modification of Privileges Request Form

Practitioner:

Specialty:

Addition:

I am requesting the following change(s) to my existing privileges:

_____

I am including documentation of my training and experience to support this request.

Deletion:

I will no longer be performing the following privilege(s):

_____

_____

_____ _____
Physician Signature Date

Received by Community Hospitals and Wellness Centers
Medical Staff Office:

_____ _____
Medical Staff Office Date

Approvals:

Credential Committee Chair: _____ Date: _____

Medical Staff Approval Date: _____ Board of Directors Date: _____

(Attachment 2)

Change in Staff Status Form

Practitioner: _____

Specialty: _____

I am requesting that my status be changed from _____ to _____.

_____ _____
Signature Date

Medical Staff Office to complete this section: _____/_____
Initials Date

Appointment date: _____ Last reappointment date: _____

Practitioner's current staff status: _____

Proctoring complete for advancement? NO YES NA

If no, how many proctoring reports have been submitted to the medical staff office? _____

Does practitioner meet requirements for staff category requesting? YES NO

If no, what requirements are not met? _____

_____

Received by Community Hospitals and Wellness Centers
Medical Staff Office:

_____ _____
Medical Staff Office Date

Approvals:

Credential Committee Chair: _____ Date: _____

Medical Staff Approval Date: _____ Board of Directors Date: _____