FERNANDEZ HOSPITAL

A unit of FERNANDEZ FOUNDATION

PRIVILEGES IN NEONATOLOGY

Name: Dr. Samyuktha

MEDICAL STAFF CATEGORY REQUESTED

Note – Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges

☐ **Full Time** – Uses Fernandez Hospitals as a primary hospital and regularly treats, consults, patients at this facility, and is regularly involved in medical staff functions.

Appointment as: - *Consultant* ☐ *Registrar* ☑ *Postdoctoral* ☐ *DNB Student* ☐

INITIAL CRITERIA

Successful completion of MBBS and ☑ MD ☐ DNB ☐ PhD ☐ DM

From a MCI recognised medical college or university. Should be registered with **AP Medical Council**

CORE PRIVILEGES				
REQUESTED	**PROCEDURE**	**GRANTED**		
		YES	**NO**	**Under Supervision**
☑	Evaluation, diagnosis, treatment and consultation for term, preterm, and critically ill newborns and infants. Neonatologist management of patients requiring ventilator care, neurological, post-neurosurgical, postsurgical, or post-cardiac / thoracic surgical care for organ dys-function, patients with issues due to prematurity and / or who are in need of critical care for life threatening disorders	☑	☐	☐
PRIMARY SPECIALTY AREAS				
☑	High frequency ventilation	☐	☐	☑
☑	Neonatal and Pediatric inter facility transport	☑	☐	☐
☐	Pulmonary artery catheter insertion and interpretation	☐	☐	☐
☐	Echocardiography (screening echocardiogram)	☐	☐	☐
☐	Nitrous Oxide administration	☐	☐	☐
☑	Parenteral nutrition	☑	☐	☐
☐	Extracorporeal membrane oxygenation (ECMO)	☐	☐	☐
☐	Emergency bedside ultrasound / echocardiography	☐	☐	☐
☐	Screening ultrasound (bedside screening ultrasonography)	☐	☐	☐
☑	Lumbar puncture	☑	☐	☐
☑	Umbilical artery catheter and umbilical vein catheter line insertion	☑	☐	☐
☑	Thoracentesis	☐	☐	☑
☑	Double volume exchange transfusion	☑	☐	☐
☑	Tube thoracostomy	☐	☐	☑
☑	Suprapubic bladder aspiration	☑	☐	☐
☐	Percutaneous indwelling arterial line	☐	☐	☐
☐	Pericardiocentesis	☐	☐	☐
☐	Paracentesis	☐	☐	☐
☑	Exogenous surfactant administration	☑	☐	☐
☐	Venous cut down	☐	☐	☐
☐	Peripheral arterial cut down	☐	☐	☐
☑	Conventional mechanical ventilation	☐	☐	☑

CORE PRIVILEGES				
REQUESTED	PROCEDURE	GRANTED		
		YES	NO	Under Supervision
☑	Endotracheal intubation	☑	☐	☐
☐	Emergency tracheostomy	☐	☐	☐
☐	Intra-umbilical vessel cut down	☐	☐	☐
☑	Therapeutic hypothermia	☐	☐	☑
☑	Non-invasive respiratory support (e.g., CPAP, HHFNC, NIPPV)	☑	☐	☐

SPECIAL PRIVILEGES (MUST ALSO MEET THE CRITERIA ABOVE)				
ADDITIONAL CREDENTIALING CRITERIA				
In accordance with Hospital Sedation Policy				Yes / No
Documentation of Additional training and experience				Yes / No
REQUESTED	PROCEDURE	YES	NO	Under Supervision
☑	Administration of Sedation	☑	☐	☐
☐	Extracorporeal Membrane Oxygenation (ECMO)	☐	☐	☐

ACKNOWLEDGMENT OF PRACTITIONER

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 Fernandez Hospital. I also acknowledge that my professional malpractice insurance extends to all privilege I have requested.

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.

Applicant Signature: M. Sangeeta Date : 04/7/19.

HOD's Signature: Rajiv Date : 05/7/19.

TO BE COMPLETED BY CHIEF EXECUTIVE OFFICER FERNANDEZ HOSPITAL AT TIME OF REVIEW AND APPROVAL

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his / her training and experience, and recommend that his / her application proceed.

Signature: [signature] Date 6/7/19