Contra Costa Regional Medical Center
Privileges Request Form

Practitioner Name: _____

Departments (s)	Number	Privilege Descriptions D= With Direct Supervision U= Unrestricted	D/C/U	Training/ Education	Experience	Current Competence	Requested	Granted	D= Denied P= Pending CNM=Criteria Not Met
		Chronic Pain Management							
	PAIN 1	**Diagnotic and Therapeudic Injections:** Requiring fluoroscopic guidance, including epidural, caudal spinal, facet joint, selective nerve sleeve, discogram peripheral ganglion, and sympathetic blocks *	D	FP, ANE, IR	N/A	N/A			
			U	Successful Completion of Fellowship in Pain Management	10	4 cases in last 2 years			
			U	FP, ANE, IR	10	4 cases in last 2 years			
	PAIN 2	Placement of Spinal Drug Delivery Systems for Outpatient Use *	D	FP, ANE, IR	N/A	N/A			
			U	Successful Completion of Fellowship in Pain Management	10	4 cases in last 2 years			
			U	FP, ANE, IR	10	4 cases in last 2 years			
	PAIN 3	Placement of Centeral or Peripheral Neurostimulation Systems *	D	FP, ANE, IR	N/A	N/A			
			U	Successful Completion of Fellowship in Pain Management	10	4 cases in last 2 years			
			U	FP, ANE, IR	10	4 cases in last 2 years			
	PAIN 4	Percutaneous Neuroablative Procedures *	D	FP, ANE, IR	N/A	N/A			
			U	Successful Completion of Fellowship in Pain Management	10	4 cases in last 2 years			
			U	FP, ANE, IR	10	4 cases in last 2 years			

*** Separate proctoring required**

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Practitioner Name: _____

Departments (s)	Number	Privilege Descriptions D= With Direct Supervision U= Unrestricted	D/C/U	Training/ Education	Experience	Current Competence	Requested	Granted	D= Denied P= Pending CNM=Criteria Not Met
	PAIN 5	Lumbar Kyphoplasty	D	FP, ANE, IR	N/A	N/A			
			U	Successful Completion of Fellowship in Pain Management	10	4 cases in last 2 years			
			U	FP, ANE, IR	10	4 cases in last 2 years			
	PAIN 6	Evaluation and Management of Chronic Pain Patients for Providers without General Outpatient Privileges	D	FP, ANE, IR	N/A	N/A			
			U	Successful Completion of Fellowship in Pain Management	10	4 cases in last 2 years			
			U	FP, ANE, IR	10	4 cases in last 2 years			

I certify that I have reviewed the Contra Costa Regional Medical Center Privilege Criteria, and that I meet the specified criteria for education/training, experience, and current competence for the privileges that I have indicated above.

Signature of Requesting Practitioner _____ Date _____

Signature of Department Chairperson _____ Date _____

*** Separate proctoring required**