DETROIT MEDICAL CENTER

AUDIOLOGY AND SPEECH PATHOLOGY
ADULT/PEDIATRIC
REQUEST FOR PRIVILEGES

Applicant Name: ____

PLEASE PRINT

QUALIFICATIONS*:*

- Graduate of a college or university, plus two years post-graduate training in Speech-Language Pathology and/or Audiology.
- Masters Degree in Speech-Language Pathology or Audiology.
- Certificate of Clinical Competence (CCC) in Audiology (CCC-A) or Speech-Language Pathology (CCC-SLP) from the American Speech Language Hearing Association (ASHA). If not current holder of the CCC, the applicant must obtain this CCC within 3 months of start of employment. Failure to do so will result in revoking of clinical privilege.
- **Michigan State Licensure in Speech Pathology or Audiology (as required by the State of Michigan)**
- Provisional privileges may be granted to Clinical Fellowship Year (CFY) candidates for Speech-Language Pathology or Audiology **under the supervision/direction of staff Audiologists or Speech-Language Pathologists.**

All provisions of specific services shall be in accordance with written departmental and DMC policies and procedures governing Allied Health Professionals.

Special Procedures:
Documentation of training and/or current experience in the privileges requested.

Observation/Proctoring Requirements: Performance is monitored through the departmental quality assessment and improvement activities.

Reappointment: Current demonstrated competence and at least **20** procedures in the previous two years with acceptable results in the privileges requested as determined through quality assessment and improvement activities and outcomes.

PRIVILEGES REQUESTED:

(R)-Requested (A)-Recommend Approval as Requested (C)-Recommend with Conditions (N)-Not Recommended

Note: *If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason must be stated below or on the last page of this form and discussed with the practitioner.*

Applicant: Please place a check mark in the (R) column ONLY for each privilege requested.

I AM APPLYING FOR PRIVILEGES TO TREAT THE FOLLOWING PATIENTS (Check one or both):

☐ **ADULT** **AND / OR** ☐ **PEDIATRIC**

AUDIOLOGY AND SPEECH PATHOLOGY – REQUEST FOR PRIVILEGES

Applicant Name ____

PLEASE PRINT

(R)	(A)	(C)	(N)	**CORE PRIVILEGES AUDIOLOGY AND SPEECH PATHOLOGY**
☐	☐	☐	☐	Clinically evaluate and diagnose causal factors for speech, swallowing, voice and/or language impairments
☐	☐	☐	☐	Clinically evaluate and diagnose causal factors in hearing impairments
☐	☐	☐	☐	Administer diagnostic testing procedures for speech, swallowing, voice and/or language impairments
☐	☐	☐	☐	Administer diagnostic testing procedures for hearing impairments
☐	☐	☐	☐	Tuning fork test
☐	☐	☐	☐	Whispered speech test
☐	☐	☐	☐	Stapedial reflex response
☐	☐	☐	☐	Thermal test of vestibular function
☐	☐	☐	☐	Rotation tests
☐	☐	☐	☐	Dysphagia training
☐	☐	☐	☐	Esophageal or tracheoesophageal speech training
☐	☐	☐	☐	Speech deficit training
☐	☐	☐	☐	Subjective audiometry
☐	☐	☐	☐	Develop individualized treatment programs
☐	☐	☐	☐	Develop and maintain long and short term treatment objectives
☐	☐	☐	☐	Re-evaluate and modify treatment programs as warranted

(R)	(A)	(C)	(N)	**SPECIAL PROCEDURES IN AUDIOLOGY AND SPEECH PATHOLOGY** (See Qualifications, Page 1)
☐	☐	☐	☐	Bekesy 5-tone audiometry
☐	☐	☐	☐	Impedance audiometry
☐	☐	☐	☐	Tympanogram, performance and interpretation
☐	☐	☐	☐	Audiology evaluation by: Barany noise machine, blindfold test, delayed feedback, masking, Weber lateralization, Dysphagia training
☐	☐	☐	☐	Auditory brain stem response
☐	☐	☐	☐	Oto acoustic emission test
☐	☐	☐	☐	Intraoperative 7th and 8th cranial nerve function testing
☐	☐	☐	☐	Fitting and/or dispensing of hearing aids **with** Otolaryngologist or other physician

Applicant Name ____

PLEASE PRINT

SPECIAL PROCEDURES IN AUDIOLOGY AND SPEECH PATHOLOGY - Continued

(R)	(A)	(C)	(N)	
☐	☐	☐	☐	Modified barium swallow with analysis **with** Radiologist
☐	☐	☐	☐	Fiberoptic endoscopic evaluation of swallow **with** Otolaryngologist or other physician
☐	☐	☐	☐	Laryngovideostroboscopy **with** Otolaryngologist or other physician

Acknowledgment of Practitioner

By my signature below, I acknowledge that I have read and understand this delineation of privilege form and applicable standards, qualifications, and criteria for privileges.

______________________________ ______________________

Applicant Signature Date

RECOMMENDATIONS

CHIEF OF SERVICE FROM HIRING DEPARTMENT:

☐ Approved as requested ☐ Approved **with conditions/modifications, as listed below.**

☐ Do not recommend

______________________________ ______________________

Signature, Chief of Service Date

MODIFICATIONS/CONDITIONS

Privileges	Modification/Condition

PEDIATRIC CHIEF OF SERVICE (If Pediatric Special Procedures or CHM Only)

☐ Approved as requested ☐ Approved **with conditions/modifications, as listed above.**

☐ Do not recommend

______________________________ ______________________

Signature, Pediatric Chief of Service Date

______________________________ ______________________

Signature, Chair of MSOC (Chief of Staff) Date

AUDIOLOGY AND SPEECH PATHOLOGY – REQUEST FOR PRIVILEGES

Applicant Name ____

PLEASE PRINT

SPECIALIST-IN-CHIEF:
I certify that I have reviewed and evaluated the applicant's request for clinical privileges, credentials and other supporting documentation, and the recommendation that is made below takes all pertinent factors into consideration.

☐ Approved as requested ☐ Approved **with conditions/modifications, as listed.**

☐ Do not recommend

______________________________________ ______________________

Signature, Specialist-in-Chief (or Designee) Date

Joint Conference Committee Action: ______________________

Date

JCC Approved 12.22.09
JCC Revised 04.28.17