Neonatal-perinatal medicine

Background

Neonatal-perinatal medicine is the subspecialty of pediatrics that involves the diagnosis and treatment of high-risk newborns. Neonatologists, the practitioners of neonatal-perinatal medicine, are trained to identify high-risk pregnancies and are familiar with the methods used to evaluate fetal well-being and maturation. They are also knowledgeable about the factors that may compromise the fetus during the intrapartum period and can recognize the signs of fetal distress.

Neonatologists generally provide the following care:

➤ Diagnose and treat newborns with conditions such as breathing disorders, infections, and birth defects
➤ Coordinate care and medically manage newborns who are born premature, critically ill, or in need of surgery
➤ Ensure that critically ill newborns receive the proper nutrition for healing and growth
➤ Provide care to the newborn during a cesarean or other delivery that involves medical problems in the mother or baby that may compromise the infant’s health and require medical intervention in the delivery room

Neonatologists generally practice in children’s hospitals, university medical centers, and large community hospitals. In these facilities, they work mainly in special care nurseries or newborn ICUs (NICU). In some cases, after a newborn has been discharged from the NICU, neonatologists may provide short-term follow-up care on an outpatient basis. They then often coordinate care with the newborn’s pediatrician.

Neonatologists are medical doctors who have completed three years of residency training in an Accreditation Council for Graduate Medical Education (ACGME)- or American Osteopathic Association (AOA)-accredited general pediatrics program, followed by three years of training in an ACGME- or AOA-accredited neonatal-perinatal program. Neonatologists may receive specialty and subspecialty certification from the American Board of Pediatrics (ABP) or from the AOA through the American Osteopathic Board of Pediatrics (AOBP).

Involved specialties

Neonatologists
Positions of specialty boards

**ABP**

The ABP offers a certificate of special qualifications in neonatal-perinatal medicine. To meet the general eligibility criteria for subspecialty certification by the ABP, candidates must:

➤ Have achieved initial certification in general pediatrics by the ABP and continue to maintain general pediatrics certification.

➤ Hold a valid, unrestricted license to practice medicine in one of the states, districts, or territories of the United States or a province of Canada in which they practice or have unrestricted privileges to practice medicine in the U.S. Armed Forces. An applicant who is practicing exclusively abroad may be exempted from this license requirement upon presentation of proof of licensure in the country in which he or she practices.

➤ Provide verification of fellowship training.

➤ Meet the ABP requirement for scholarly activity/research during fellowship training.

In addition to meeting the general eligibility criteria, candidates must also accomplish the following in order to become certified in the subspecialty of neonatal-perinatal medicine:

➤ Complete three years of full-time, broad-based fellowship training in neonatal-perinatal medicine in a program accredited for training in neonatal-perinatal medicine by the Review Committee for Pediatrics in the United States or the Royal College of Physicians and Surgeons in Canada.

➤ A Verification of Competence Form must be completed by the program director(s) verifying satisfactory completion of the required training, evaluating clinical competence including professionalism, and providing evidence of scholarly activity/research.

➤ The fellow must meet either the criteria stated in the “Principles Regarding the Assessment of Scholarly Activity” or the criteria stated in the “Principles Regarding the Assessment of Meaningful Accomplishment in Research” as described in the *General Criteria for Certification in the Pediatric Subspecialties*. Fellows who began training on or after July 1, 2004, must meet the requirements for scholarly activity.

➤ Pass the subspecialty certifying examination.

**AOBP**

The AOBP offers a certificate of special qualifications in neonatology. To become certified in a neonatology by the AOBP, candidates must meet the following minimum requirements:

➤ Be certified in pediatrics by the AOA through the AOBP

➤ If training was completed prior to January 1, 1980, one year of AOA-approved subspecialty residency training and two years of subspecialty practice are required
If training was completed between January 1, 1980, and December 31, 1989, two years of AOA-approved subspecialty residency training and one year of subspecialty practice are required.

If training was completed after on or after January 1, 1990, three years of AOA-approved subspecialty residency training are required.

Positions of societies, academies, colleges, and associations

AAP

The American Academy of Pediatrics (AAP) publishes the policy statement Medical Staff Appointment and Delineation of Pediatric Privileges in Hospitals. In the statement, the AAP says that a major portion of the credentialing process is the delineation of clinical privileges. By this process, the medical staff evaluates and recommends that an individual practitioner be allowed to provide specific patient care services in the hospital based on the hospital’s mission and needs and the practitioner’s training, experience, and skills. Privileges may be denied to an applicant if the hospital does not have the facilities for the requested procedure (e.g., a pediatric cardiologist who requests privileges for cardiac catheterization from a hospital that does not have catheterization facilities).

Departments within the hospital are responsible for defining the minimum education, training, and experience that a practitioner must possess to deliver care of varying complexity or perform specific procedures. This may be done across departments when practitioners of various disciplines care for patients (e.g., pediatrics and nursing for nurse practitioners).

Once criteria are established, they must be written and applied equitably to practitioners from different specialties (e.g., pediatrics, family practice, and surgery). Criteria for clinical privileges are based on the complexity of care needed by the patient (e.g., routine inpatient, routine newborn, subspecialty, or intensive care).

Criteria for privileges for procedures can be based on the levels of care, documentation of training, and continued competence in the procedures. Research has shown that skills in some procedures (e.g., laparoscopy or surgical procedures) improve with repeated use until a set number is reached. Other data have shown that patient outcomes are improved for some procedures when a minimum number are performed in a hospital.

Competency for procedures also can be determined by evaluation of performance under clinical conditions (i.e., proctorship). Checklists may be used by the practitioner requesting privileges to document levels of care and procedures requested.

Questions are often raised about how one determines whether an applicant is competent to care for children in the hospital if he or she is not a pediatrician.
or pediatric-trained specialist or subspecialist. Board certification or eligibility in pediatrics or a pediatric subspecialty or training in a pediatric specialty is assumed to define a basic set of skills and knowledge needed to care for sick children.

Many non-pediatricians can document by their training and experience that they are competent in caring for children of various ages and with various severity of illness. Experience in procedures performed on children should also be documented.

As new procedures and treatment modalities develop, guidelines for clinical privileges must also develop. New procedures and treatment modalities can be divided into major new procedures (e.g., endoscopy or laparoscopic surgery) or minor changes (e.g., a new way to perform laparoscopic surgery).

Practitioners wishing to be granted privileges in a major new procedure or treatment modality must document sufficient hands-on training to be deemed competent. Physicians may gain this training through supervised training programs. A practitioner may also gain provisional privileges that allow him or her to perform the procedure under the supervision of another practitioner skilled in the procedure (i.e., proctoring).

Data from some new procedures have shown that the complication rate decreases significantly and competency increases significantly after a certain number of the procedures are performed. Guidelines for competency in new procedures or treatment modalities must be developed on the basis of a review of the literature and technical aspects of the procedure. Once the practitioner successfully meets the guidelines, full privileges are granted.

**ACGME**

In its *Program Requirements for Graduate Medical Education in Neonatal-Perinatal Medicine*, the ACGME states that with regard to patient care, fellows in neonatal-perinatal medicine must be directly involved in the care of critically ill surgical patients in order to acquire the requisite specialty-specific knowledge and skills to attain competence in the evaluation, diagnosis, and pre-/postoperative management of such patients. To meet these goals, the coordination of care and collegial relationships between pediatric surgeons, neonatologists, and critical care intensivists concerning the management of medical problems in these complex critically ill patients are essential. Fellows must:

➤ Have experience and instruction adequate for them to manage critically ill neonates. In addition to the general principles of critical care, this should include, but not be limited to, techniques of neonatal resuscitation, venous and arterial access, evacuation of air leaks, endotracheal intubation, preparation for transport, ventilatory support, continuous monitoring, temperature control, and nutritional support.
Have instruction in the psychosocial implications of disorders of the fetus, neonate, and young infant, as well as in the family dynamics surrounding the birth and care of a sick neonate. The fellows should have experience in patient consultation, communication with referring physicians, and organizing transport of neonates within the framework of an integrated regional system with different levels of perinatal care. They should also receive instruction about and participate in the education of physicians and other healthcare professionals regarding emerging issues and factors impacting regional perinatal morbidity and mortality.

Learn to identify high-risk pregnancies and become familiar with the methods used to evaluate fetal well-being and maturation. Fellows must become familiar with factors that may compromise the fetus during the intrapartum period and recognize the signs of fetal distress. In addition, fellows must participate in the follow-up of high-risk neonates.

Programs must teach fellows to be effective consultants in neonatal-perinatal medicine. All fellows must receive instruction that prepares them to conduct and interpret relevant scholarly efforts in neonatal-perinatal medicine, to teach neonatal-perinatal medicine effectively, and to be effective administrators and leaders in the field.

To become skilled in diagnosis and management, fellows must be exposed to critically ill neonates with diverse medical and surgical conditions. Fellows must participate in the care of a sufficient number of neonates who require ventilatory assistance in order to become skilled in their management; fellows should also participate in the care of neonates requiring major surgery. In addition, fellows must acquire knowledge of, and participate in, the care of neonates requiring cardiac surgical procedures (and their postoperative complications).

A neonatal database of all patient admissions, diagnoses, and outcomes must be used for fellow education. Programs should provide fellows with knowledge about the tabulation and evaluation of an institutional database. Exposure to a regional or national fetal and neonatal morbidity and mortality database is encouraged. There should also be instruction and experience in techniques of collation and critical interpretation of data pertaining to immediate outcome and sequelae of various diseases, for which the presence of a statistician is suggested. This experience should be closely related to the evaluations of various modalities of therapy used in these disorders.

With regard to medical knowledge, the program must provide fellows with instruction in related basic sciences. Seminars, conferences, and courses must be offered in the basic disciplines related to pregnancy, the fetus, and the neonate. This should include maternal physiological, biochemical, and pharmacological influences on the fetus; fetal physiology; fetal development; placental function (placental circulation, gas exchange, growth); physiological and biochemical adaptation to birth; cellular, molecular, and developmental biology and
pathology relevant to diseases of the neonate; psychology of pregnancy and maternal-infant interaction; breast-feeding and lactation; growth and nutrition; and genetics.

Fellows should also participate in regularly scheduled multidisciplinary conferences, such as case conferences and those that review perinatal mortality and morbidity.

**AOA/ACOP**

In its *Basic Standards for Subspecialty Residency Training in Neonatal Medicine*, the AOA outlines requirements for training programs in conjunction with the American College of Osteopathic Pediatricians (ACOP). With regard to medical knowledge, the AOA states that pediatric residents are expected to demonstrate and apply knowledge of accepted standards of clinical pediatrics, remain current with new developments in pediatrics, and participate in lifelong learning activities, including research. Residents must:

- Demonstrate competency in the understanding and application of clinical pediatrics to patient care
- Know and apply the foundations of clinical and behavioral pediatrics

With regard to patient care, pediatric residents must demonstrate the ability to effectively treat patients, providing medical care that incorporates the osteopathic philosophy, patient empathy, awareness of behavioral issues, preventive medicine, and health promotion. Residents must have the ability to:

- Gather accurate, essential information for all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic plans and treatments
- Validate competency in the performance of diagnosis, treatments, and appropriate procedures
- Provide healthcare services consistent with osteopathic philosophy, including preventive medicine and health promotion, that are based on current scientific evidence and understanding of behavioral medicine

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for neonatal-perinatal medicine. However, the CMS *Conditions of Participation (CoP)* define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws,
rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

➤ Individual character
➤ Individual competence
➤ Individual training
➤ Individual experience
➤ Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

The Joint Commission

The Joint Commission has no formal position concerning the delineation of privileges for neonatal-perinatal medicine. However, in its Comprehensive Accreditation Manual for Hospitals, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate
the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.” It goes on to state that this process typically includes:

➤ Developing and approving a procedures list
➤ Processing the application
➤ Evaluating applicant-specific information
➤ Submitting recommendations to the governing body for applicant-specific delineated privileges
➤ Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
➤ Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for standard MS.06.01.05 include several requirements as follows:

➤ The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
➤ Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
➤ Consistent application of criteria
➤ A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
➤ Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
➤ A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
➤ Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
➤ A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
➤ A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
➤ A decision (action) on the completed application for privileges that occurs within the time period specified in the organization’s medical staff bylaws
➤ Information regarding any changes to practitioners’ clinical privileges, updated as they occur
The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

**HFAP**

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for neonatal-perinatal medicine. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.
In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

**DNV**

DNV has no formal position concerning the delineation of privileges for neonatal-perinatal medicine. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
- Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status
- Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).
Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

**CRC draft criteria**

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding this practice area. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.

**Minimum threshold criteria for requesting privileges in neonatal-perinatal medicine or neonatology**

**Basic education:** MD or DO

**Minimal formal training:** Successful completion of an ACGME- or AOA-accredited fellowship in neonatal-perinatal medicine or neonatology and/or current subspecialty certification or active participation in the examination process (with achievement of certification within [n] years) leading to subspecialty certification in neonatal-perinatal medicine by the ABP or in neonatology by the AOBP.

**Required current experience:** Provision of inpatient or consultative services, reflective of the scope of privileges requested, to at least 50 neonatal patients during the past 12 months or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

**References**

If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

**Core privileges in neonatal-perinatal medicine**

Core privileges for neonatal-perinatal medicine include the ability to admit, evaluate, diagnose, treat, and provide consultation for sick newborns presenting with any life-threatening problems or conditions, such as breathing disorders,
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infections, and birth defects. Privileges also include the ability to coordinate care and medically manage newborns who are born prematurely, critically ill, or in need of surgery; provide consultation to mothers with high-risk pregnancies; provide care to patients in the newborn nursery and NICU in conformance with unit policies; and assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the following procedures list and such other procedures that are extensions of the same techniques and skills:

➤ Performance of history and physical exam
➤ Attendance at delivery of high-risk newborns
➤ Bone marrow aspiration
➤ Cardiac life support, including emergent cardioversion
➤ Endotracheal intubation
➤ Exchange transfusion
➤ Insertion and management of central lines
➤ Insertion and management of chest tubes
➤ Lumbar puncture
➤ Neonatal resuscitation
➤ Nutritional support
➤ Paracentesis, thoracentesis, pericardiocentesis
➤ Peripheral arterial artery catheterization
➤ Peritoneal dialysis with consultation as appropriate
➤ Postoperative care of newborns
➤ Preliminary EKG interpretation
➤ Suprapubic bladder tap
➤ Umbilical catheterization
➤ Ventilator care of infants beyond emerging stabilization

Special noncore privileges in neonatal-perinatal medicine

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence. Noncore privileges include:

➤ Extracorporeal membrane oxygenation
➤ Administration of sedation and analgesia

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism.

Applicants in neonatal-perinatal medicine must be able to document that they have current demonstrated competence and an adequate volume of experience
(100 neonatal patients) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

In addition, continuing education related to neonatal-perinatal medicine should be required.

For more information

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Fax: 847/228-5097
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**American Board of Pediatrics**
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Fax: 919/929-9255
Website: [www.abp.org](http://www.abp.org)

**American Osteopathic Association**
142 East Ontario Street
Chicago, IL 60611
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Website: [www.aoa-net.org](http://www.aoa-net.org)

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Website: [www.aobp.org](http://www.aobp.org)

**Centers for Medicare & Medicaid Services**
7500 Security Boulevard
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