Rheumatology

Background

Rheumatology is the subspecialty of internal medicine concerned with the diagnosis and treatment of arthritis and other diseases of the joints, muscles, and bones. According to the National Institute of Arthritis and Musculoskeletal and Skin Diseases, rheumatic diseases—which typically cause pain, swelling, disability, deformity, and/or loss of function in the affected area—include the following:

- Various types of arthritis (e.g., osteoarthritis, rheumatoid arthritis, infectious arthritis, psoriatic arthritis, spondyloarthropathies, and gout)
- Fibromyalgia
- Systemic lupus erythematosus
- Scleroderma
- Polymyalgia rheumatica
- Polymyositis
- Bursitis
- Tendonitis

Rheumatologists can provide valuable expertise and insight into the management of such rheumatic diseases, as well as musculoskeletal diseases such as osteoporosis. Rheumatologic conditions can be difficult to diagnose, particularly in the early stages, and may be difficult to treat. According to the American College of Rheumatology (ACR), rheumatologists should be consulted when a patient is suffering inflammation or loss of function that cannot be explained by a recent injury, and when an injury is not improving as expected with treatment. Some rheumatologic diseases are serious—even fatal—and require close monitoring. Consequently, rheumatologists may serve as primary care physicians for patients with chronic, serious rheumatologic conditions.

Following medical school, rheumatologists complete a residency in internal medicine and complete an accredited fellowship training program in rheumatology approved by the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA).

Fellowship training in rheumatology must be a minimum of two years in duration. Rheumatology subspecialty training focuses on the prevention, diagnosis, evaluation, and management of a wide variety of rheumatic and musculoskeletal diseases and other illnesses with rheumatologic musculoskeletal manifestations.

For certification in rheumatology, physicians sit for the examination offered by the American Board of Internal Medicine (ABIM) or the American Osteopathic Board...
of Internal Medicine (AOBIM). Candidates for the ABIM certification process in rheumatology must first pass the written exam for internal medicine and then pass the rheumatology exam. The AOBIM also limits eligibility for board certification in rheumatology to persons who are already diplomates in osteopathic internal medicine. Those seeking AOBIM certification in rheumatology must pass a daylong written exam.

**Involved specialties**
Rheumatologists

**Positions of specialty boards**

**ABIM**

To become certified in the subspecialty of rheumatology through the ABIM, physicians must:
➤ Be previously certified in internal medicine by the ABIM
➤ Satisfactorily complete the requisite graduate medical education and fellowship training accredited by the ACGME, the Royal College of Physicians and Surgeons of Canada, or the Professional Corporation of Physicians of Quebec
➤ Demonstrate clinical competence, procedural skills, and moral and ethical behavior in the clinical setting
➤ Hold a valid, unrestricted, and unchallenged license to practice medicine
➤ Pass the Rheumatology Certification Exam

Candidates for subspecialty certification must meet the ABIM’s requirements for duration of training as well as minimum duration of full-time clinical training. Fellowship training in rheumatology must be a minimum of 24 months in duration, with 12 months devoted to clinical experience.

Candidates for certification must be able to demonstrate their competence in performing the following requisite procedures:
➤ Diagnostic aspiration of and analysis by light and polarized light microscopy of synovial fluid from diarthrodial joints, bursae, and tenosynovial structures
➤ Therapeutic injection of diarthrodial joints, bursae, tenosynovial structures, and entheses

The ABIM also offers dual certification in rheumatology and allergy and immunology, which requires a minimum of three years of training that includes:
➤ At least 12 months of clinical rheumatology training supervised by the director of an accredited rheumatology training program
➤ 18 consecutive months of experience in a rheumatology continuity clinic
➤ At least 18 months of allergy and immunology training supervised by the training program director of an accredited program in allergy and immunology
**AOBIM**

The AOA grants certification in the subspecialty of rheumatology through the AOBIM. To be eligible to receive certification, applicants must meet all of the following minimum requirements:

- Be certified by the AOA, through the AOBIM, in internal medicine
- Satisfactorily complete 24 months of an AOA-approved fellowship program in rheumatology
- Successfully pass a comprehensive, one-day written/clinical exam

**Positions of societies, academies, colleges, and associations**

**ACR**

The ACR is an organization that advances rheumatology through programs of education, research, advocacy, and practice support that foster excellence in the care of patients with arthritis and rheumatic and musculoskeletal diseases.

Imaging studies of the musculoskeletal system provide physicians with information critical to the diagnosis, evaluation of damage, and progression of arthritic diseases. Therefore, the U.S. directors of rheumatology training programs have sanctioned a core curriculum to ensure program quality and consistency for proficiency in the interpretation of bone and joint imaging. This core curriculum requires that rheumatology fellows and those individuals in clinical practice demonstrate understanding and competency in:

- The x-ray assessment of normal and diseased joints, bones, periarticular structures, and prosthetic joints
- The evaluation of results from other diagnostic imaging techniques of the musculoskeletal system, including CT, MRI, radionuclide scans, ultrasonography, and bone mineral densitometry

Because rheumatologists have a comprehensive understanding of the clinical issues affecting their patients, they are particularly well qualified to order and interpret appropriate imaging studies. Additionally, imaging of the musculoskeletal system of patients, when done in the context of providing direct care to the patient, results in more focused and proper care. Therefore, in its position statement on diagnostic imaging credentialing, the ACR states that it supports:

- The performance and/or interpretation of imaging studies of the musculoskeletal system as an integral part of the rheumatology practice.
- The propriety of the assessment and collection of appropriate fees for these services. The ACR supports insurance reimbursement by Medicare and other insurers for the performance and interpretation of musculoskeletal imaging studies and bone mineral density measurements by rheumatologists.
The ACR is accredited by the ACGME to provide continuing medical education to its physicians. In addition, it promotes the art and science of medicine through print and electronic publications, research grants, and meetings for its members and other professional healthcare providers who deal with rheumatic diseases.

**ACGME**

In its *Program Requirements for Fellowship Education in Rheumatology*, the ACGME states that a subspecialty program in rheumatology must provide training and supervised experience sufficient for the physician to acquire the competency of a specialist in the field. The two years of fellowship training in rheumatology include 12 months of clinical experience and at least two half-days of ambulatory care per week, averaged over 24 months.

With regard to patient care, fellows must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of patients of each gender, from adolescence to old age, during health and all stages of illness. Fellows must demonstrate competence in treating the following disorders:

- Crystal-induced synovitis
- Infection of joints and soft tissues
- Metabolic diseases of bone
- Nonarticular rheumatic diseases, including fibromyalgia
- Nonsurgical exercise-related (sports) injury
- Osteoarthritis
- Osteoporosis
- Pediatric rheumatic diseases (it is suggested that programs with the qualified faculty members and facilities provide training)
- Polymyositis
- Regional musculoskeletal pain syndromes, acute and chronic musculoskeletal pain syndromes, and exercise-related syndromes
- Rheumatoid arthritis
- Scleroderma/systemic sclerosis
- Sjögren’s syndrome
- Spondyloarthropathies
- Systemic diseases with rheumatic manifestations
- Systemic lupus erythematosus
- Vasculitis

Fellows must also demonstrate competence in:

- The examination and interpretation of synovial fluid under conventional and polarized light microscopy
- The interpretation of radiographs of normal and diseased joints, bones, periarticular structures, and prosthetic joints
➤ Musculoskeletal pain assessment and management
➤ Performing arthrocentesis of peripheral joints and periarticular/soft tissue injections

With regard to medical knowledge, fellows must also demonstrate knowledge of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indications for and use of screening tests/procedures; this must include knowledge of the indications and interpretation of the following:

➤ Arteriograms (conventional and MRI/MRA) for patients with suspected or confirmed vasculitis
➤ Arthroscopy
➤ Biopsy specimens, including histochemistry and immunofluorescence of tissues relevant to the diagnosis of rheumatic diseases
➤ Bone densitometry
➤ CT of lungs and paranasal sinuses for patients with suspected or confirmed rheumatic disorders
➤ Electromyograms and nerve conduction studies for patients with suspected or confirmed rheumatic disorders
➤ MRI of the central nervous system (brain and spinal cord) for patients with suspected or confirmed rheumatic disorders
➤ Parotid scans and salivary flow studies
➤ Plain radiography, arthrography, ultrasonography, radionuclide scans, CT, and MRI of joints, bones, and periarticular structures
➤ Schirmer’s and rose Bengal tests

Fellows must also demonstrate knowledge of:
➤ The anatomy, basic immunology, genetic basis, cell biology, and metabolism pertaining to rheumatic diseases, disorders of connective tissue, metabolic disease of bone, osteoporosis, and musculoskeletal pain syndromes
➤ The pathogenesis, epidemiology, clinical expression, treatments, and prognosis of the full range of rheumatic and musculoskeletal diseases
➤ The physical and biologic basis of the range of diagnostic testing in rheumatology, and the clinical test characteristics of these procedures
➤ The pharmacokinetics, metabolism, adverse events, interactions, and relative costs of drug therapies used in the management of rheumatic disorders
➤ The aging influences on musculoskeletal function and responses to prescribed therapies for rheumatic diseases
➤ The essential components of quality experimental design, clinical trial design, data analysis, and interpretation of results; and the importance of adherence to ethical standards of experimentation
➤ The appropriate employment of principles of physical medicine and rehabilitation in the care of patients with rheumatic disorders
The indications for surgical and orthopedic consultation, including indications for arthroscopy and joint replacement/arthroplasty

AOA

In conjunction with the American College of Osteopathic Internists, the AOA publishes its *Specific Basic Standards for Osteopathic Fellowship Training in Rheumatology*. The fellowship training program is a full-time training program of a minimum of 24 months in duration, during which the fellow must participate in ambulatory clinic at least four half-days per week in the first year and two half-days per week during the second year.

With regard to medical knowledge, clinical teaching conferences must be conducted at least once weekly, and the fellow must present a minimum of four clinical lecture conferences under the guidance of a faculty member each year. The fellow must also have learning activities in:

- Use of nonsteroidal anti-inflammatory drugs, disease-modifying drugs, biologic response modifiers, glucocorticoids, cytotoxic drugs, antihyperuricemic drugs, and antibiotic therapy for septic joints
- Examination of patients, with particular skill in the examination of all joints
- Construction of differential diagnoses related to the signs and symptoms of rheumatologic diseases
- Diffuse connective tissue disease
- Rheumatoid arthritis
- Systemic lupus erythematosus
- Scleroderma
- Polymyositis
- Spondyloarthropathies
- Vasculitis
- Crystal-induced synovitis
- Osteoarthritis
- Musculoskeletal pain syndromes including fibromyalgia
- Sports injuries
- Systemic diseases with rheumatic manifestations
- Metabolic diseases of bone
- Osteoporosis
- Joint infections
- Indications and complications of joint surgery

With regard to patient care, the fellow must have training and experience in:

- Trigger point injections, joint aspiration, and joint injections (to include, at minimum, indications, contraindications, complications, limitations, interpretation, and evidence of competent performance)
- The interpretation of arthrography, ultrasonography, bone densitometry, musculoskeletal radiographs, CT, and MRI of bones, joints, and periarticular structures
Positions of accreditation bodies

**CMS**

CMS has no formal position concerning the delineation of privileges for rheumatology. 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 rheumatology. 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 rheumatology. 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 rheumatology. 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 rheumatology**

**Basic education:** MD or DO

**Minimal formal training:** Successful completion of an ACGME- or AOA-accredited residency in rheumatology and/or current subspecialty certification or active participation in the examination process (with achievement of certification within [n] years) leading to subspecialty certification in rheumatology by the ABIM or completion of a certificate of added qualifications in rheumatology by the AOBIM.

**Required current experience:** Inpatient, outpatient, or consultative services for at least 24 patients, reflective of the scope of privileges requested, 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 rheumatology

Core privileges for rheumatology include the ability to admit, evaluate, diagnose, treat, and provide consultation to patients of all ages with diseases of the joints, muscles, bones, and tendons. They also include evaluation, prevention, and management of disorders such as rheumatoid arthritis; infections of joint and soft tissue; osteoarthritis; metabolic diseases of bone; systemic lupus erythematosus; scleroderma/systemic sclerosis and crystal-induced synovitis; polymyositis; spondyloarthropathies; vasculitis; regional, acute, and chronic musculoskeletal pain syndromes; nonarticular rheumatic diseases, including fibromyalgia; nonsurgical exercise-related injury; systematic disease with rheumatic manifestations; osteoporosis; and Sjögren’s syndrome. Physicians may provide care to patients in the intensive care setting in conformance with unit policies. They may also 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
➤ Diagnostic aspiration and analysis by light and compensated polarized light microscopy of synovial fluid
➤ Therapeutic injection of diarthrodial joints, bursae, tenosynovial structures, and entheses
➤ Use of nonsteroidal anti-inflammatory drugs, disease-modifying drugs, biological-response modifiers, glucocorticoids, cytotoxic drugs, antihyperuricemic drugs, and antibiotic therapy for septic joints
➤ Performance or interpretation of:
  – Biopsies of tissues relevant to the diagnosis of rheumatic diseases
  – Bone and joint imaging techniques
  – Bone density measurements
  – Electromyograms, nerve conduction studies, and muscle/nerve biopsy

Special noncore privileges in rheumatology

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:

➤ Administration of sedation and analgesia

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism. To be eligible to renew privileges in rheumatology, the applicant must have current demonstrated competence and an adequate volume of experience (inpatient, outpatient, or consultative services for at least 48 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 rheumatology should be required.

For more information

For more information regarding this practice area, please contact:

Accreditation Council for Graduate Medical Education
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Fax: 312/755-7498
Website: www.acgme.org

American Board of Internal Medicine
510 Walnut Street, Suite 1700
Philadelphia, PA 19106
Telephone: 800/441-2246
Fax: 215/446-3590
Website: www.abim.org

American College of Rheumatology
2200 Lake Boulevard NE
Atlanta, GA 30319
Telephone: 404/633-3777
Fax: 404/633-1870
Website: www.rheumatology.org
American Osteopathic Board of Internal Medicine
1111 West 17th Street
Tulsa, OK 74107-1898
Telephone: 918/561-1267
Website: www.acoi.org

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 877/267-2323
Website: www.cms.hhs.gov

DNV Healthcare Inc.
400 Techne Center Drive, Suite 350
Milford, OH 45150
Website: www.dnvaccreditation.com

Healthcare Facilities Accreditation Program
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