Pediatric emergency medicine

Background

Pediatric emergency medicine is a medical subspecialty that focuses on the diagnosis and treatment of acute illnesses and injuries of patients under the age of 18 within the confines of the emergency department (ED) setting. These physicians provide rapid evaluations with simultaneous stabilization of any life-threatening situation. They also must be able to proceed with lifesaving interventions before arriving at a definitive diagnosis.

Pediatric emergency medicine physicians attend four years of medical school, then complete three or four additional years of training in an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)–accredited residency program in emergency medicine or pediatrics.

The American Board of Emergency Medicine (ABEM) and the American Board of Pediatrics (ABP) offer subspecialty board certification in pediatric emergency medicine. However, the requirements differ for each board. To become certified in pediatric emergency medicine by the ABEM, applicants must be certified by the ABEM in emergency medicine and have subsequently completed a two-year fellowship in pediatric emergency medicine. To become certified in pediatric emergency medicine by the ABP, applicants must be certified in pediatrics by the ABP and have completed a three-year fellowship in pediatric emergency medicine.

For more information, please see the following Clinical Privilege White Papers:
➤ Practice area 152—Pediatrics
➤ Practice area 133—Emergency medicine

Involved specialties

Pediatric emergency medicine physicians

Positions of specialty boards

ABP

To become certified in pediatric emergency medicine by the ABP, physicians must:
➤ Be certified in pediatrics by the ABP
➤ 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

➤ Provide verification of training in a pediatric emergency medicine fellowship program
- Physicians who entered training in pediatric emergency medicine on or after July 1, 2001, are required to complete their training in a program accredited for training in pediatric emergency medicine by the Review Committee (RC) for Pediatrics or the RC for Emergency Medicine in the United States or the Royal College of Physicians and Surgeons of Canada
- A subspecialty fellow who entered pediatric emergency medicine training before January 1, 1995, may apply for admission on the basis of completion of two years of fellowship training in pediatric emergency medicine
- Three years of full-time, broad-based fellowship training in pediatric emergency medicine are required for fellows entering training on or after January 1, 1995

Fellows who began fellowship training in pediatric emergency medicine on or after January 1, 1995, must also meet the following requirements:

➤ 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 Sub specialties. Fellows who began training after July 1, 2004, must meet the requirements for scholarly activity;
➤ The fellow must pass the subspecialty certifying examination.

Additionally, fellows who began fellowship training in pediatric emergency medicine after July 1, 2004, must meet these requirements:

➤ Meet the board’s requirements for scholarly activity, which require that the physician play a substantial role in a peer-reviewed publication or complete any one of the other options outlined by the board
➤ Provide evidence of meaningful research in any one of the options outlined by the board

A candidate who is certified by the ABP and the ABEM may apply for dual certification. Only candidates who completed training to meet certification requirements of the ABP and the ABEM before January 1, 1999, may apply for dual certification.
**ABEM**

In addition to passing an examination, physicians applying for certification in pediatric emergency medicine from the ABEM must:

➤ Be certified in emergency medicine by the ABEM
➤ Be a diplomate in good standing of the ABEM
➤ Hold a current, active, valid, full, unrestricted, and unqualified license to practice medicine
➤ Have successfully completed two years of subspecialty training in pediatric emergency medicine

Physicians who entered training on or after July 1, 2001, are required to have completed their two-year subspecialty residency training in an ACGME-accredited pediatric emergency medicine program.

A candidate certified by the ABP and the ABEM may apply for dual certification. Only candidates who completed training to meet certification requirements of the ABP and the ABEM before January 1, 1999, may apply for dual certification.

The pediatric emergency medicine subspecialty certification exam is a comprehensive multiple-choice exam that covers the breadth of the field. Certification is valid for 10 years.

**AOBEM**

The American Osteopathic Board of Emergency Medicine (AOBEM) does not offer separate certification in pediatric emergency medicine. The board is in the early stages of developing a pediatric emergency medicine certificate of added qualification.

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

**AAP/ACEP**

The American Academy of Pediatrics (AAP) and the American College of Emergency Physicians (ACEP) jointly publish a policy statement titled *Guidelines for Care of Children in the Emergency Department*, which details the resources needed to ensure that children receive quality emergency care.

The guidelines state that physicians staffing the ED should have the necessary skill, knowledge, and training in the emergency evaluation and treatment of children of all ages who may be brought to the ED, consistent with the services provided by the hospital.

According to the statement, the following policies, procedures, and protocols may be integrated into ED policies and procedures with pediatric-specific components:
➤ Illness and injury triage
➤ Pediatric patient assessment and reassessment
➤ Documentation of pediatric vital signs, abnormal vital signs, and actions to be taken for abnormal vital signs
➤ Immunization assessment and management of the underimmunized patient
➤ Sedation and analgesia for procedures, including medical imaging
➤ Consent (including situations in which a parent is not immediately available)
➤ Social and mental health issues
➤ Physical or chemical restraint of patients
➤ Child maltreatment (physical and sexual abuse, sexual assault, and neglect) mandated reporting criteria, requirements, and processes
➤ Death of the child in the ED
➤ Do-not-resuscitate orders
➤ Family-centered care, including:
  − Involve families in patient care decision-making and in medication safety processes
  − Family presence during all aspects of emergency care, including resuscitation
  − Education of the patient, family, and regular caregivers
  − Discharge planning and instruction
  − Bereavement counseling
➤ Communication with patient’s medical home or primary healthcare provider
➤ Medical imaging policies that address age- or weight-appropriate dosing for children receiving studies that impart ionizing radiation, consistent with ALARA (as low as reasonably achievable) principles
➤ All-hazard disaster preparedness plan that addresses the following pediatric issues:
  − Availability of medications, vaccines, equipment, and appropriately trained providers for children in disasters
  − Pediatric surge capacity for both injured and noninjured children
  − Decontamination, isolation, and quarantine of families and children of all ages
  − Minimizing parent-child separation and improving methods for reuniting separated children with their families
  − Access to specific medical and mental health therapies, as well as social services, for children in the event of a disaster
  − Ensuring that disaster drills include a pediatric mass casualty incident at least once every two years and that all drills include pediatric patients
  − Care of children with special healthcare needs
➤ Hospitals should have written pediatric interfacility transfer procedures that include the following pediatric components of transfer:
  − Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication)
  − Transport plan to deliver children safely and in a timely manner to the appropriate facility capable of providing definitive care
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- Process for selecting the appropriate care facility for pediatric specialty services not available at the hospital; these specialty services may include:
  - Medical and surgical specialty care
  - Critical care
  - Reimplantation (replacement of severed digits or limbs)
  - Trauma and burn care
  - Psychiatric emergencies
  - Obstetric and perinatal emergencies
  - Child maltreatment (physical and sexual abuse and assault)
  - Rehabilitation for recovery from critical medical or traumatic conditions
- Process for selecting the appropriately staffed transport service to match the patient’s acuity level (e.g., level of care required by patient, equipment needed in transport), including children with special healthcare needs
- Process for patient transfer (including obtaining informed consent)
- Plan for transfer of patient information (e.g., medical record and copy of signed transport consent), personal belongings of the patient, and provision of directions and referral institution information to family
- Process for return transfer of the pediatric patient to the referring facility as appropriate

ACEP includes the *Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine* policy statement in its pediatric policy section as well as its general credentialing and privileging section. In that statement, it states that:

➤ The exercise of clinical privileges in the ED is governed by the rules and regulations of the department
➤ The ED medical director is responsible for periodic assessment of clinical privileges of emergency physicians
➤ When a physician applies for reappointment to the medical staff and for clinical privileges, including renewal, addition, or rescission of privileges, the reappraisal process must include assessment of current competence by the ED medical director
➤ The ED medical director will, with the input of department members, determine the means by which each emergency physician will maintain competence and skills and the mechanism by which to monitor the proficiency of each physician

According to the statement, a qualified emergency physician is defined as one who possesses emergency medicine training or sufficient experience in emergency medicine to evaluate and manage all patients who seek emergency care. ACEP believes that the ED medical director should be responsible for assessing and making recommendations to the hospital’s credentialing body related to the qualifications of emergency physicians with respect to the clinical privileges granted to them. At a minimum, those applying for privileges as emergency physicians should be eligible for ACEP membership. Board certification by the ABEM or the AOBEM is an excellent but not the sole benchmark for decisions.
regarding an individual’s ability to practice emergency medicine. Other qualifications may include objective measurement of care provided, sufficient experience, prior training, and evidence of CME.

**ACGME**

In its *Program Requirements for Fellowship Education in Pediatric Emergency Medicine*, the ACGME states that all fellows must receive at least two years of training. Applicants who trained in pediatrics, as opposed to emergency medicine, must be provided with a third year of training to meet ABP requirements.

With regard to patient care, the ACGME states that fellows must have the opportunity to provide initial evaluation and treatment to all kinds of patients. They must learn to evaluate the patient with an undifferentiated chief complaint and diagnose whether it falls in areas traditionally designated as medical, surgical, or subspecialty. Fellows must also learn to perform such evaluations rapidly, with simultaneous stabilization of any life-threatening process, and to proceed with appropriate lifesaving interventions before arriving at a definitive diagnosis.

Additionally, fellows must learn the skills necessary to prioritize and simultaneously manage the emergency care of multiple patients. They must have supervised experience using their technical/procedural and resuscitation competency skills as those skills apply to pediatric patients of all ages. Accordingly, the program must demonstrate that fellows have been provided didactic training and clinical exposure to attain competency in the following procedures:

- Abscess incision and drainage
- Arterial catheterization
- Arthrocentesis
- Artificial ventilation
- Cardiac pacing, external
- CPR in all of the following groups:
  - Adult medical resuscitation (patients over 18 years)
  - Adult trauma resuscitation (patients over 18 years)
  - Pediatric medical resuscitation (patients under age 2)
  - Pediatric medical resuscitation (patients over age 2)
  - Pediatric trauma resuscitation (patients under age 2)
  - Pediatric trauma resuscitation (patients over age 2)
- Cardioversion/defibrillation
- Central venous catheterization
- Closed reduction/splinting
- Conversion of supraventricular tachycardia
- Cricothyrotomy—translaryngeal ventilation
- Dislocation/reduction
- Endotracheal intubation
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➤ Foreign body removal
➤ Gastric lavage
➤ Gastrostomy tube replacement
➤ Intraosseous access
➤ Laceration repair
➤ Nasal packing
➤ Pericardiocentesis
➤ Peritoneal lavage
➤ Rapid sequence intubation
➤ Regional nerve blocks
➤ Sedation and analgesia
➤ Slit lamp examination
➤ Tracheostomy tube replacement
➤ Tube thoracostomy
➤ Umbilical vessel catheterization
➤ Vaginal delivery

To meet the educational objectives of the program, there should be a minimum of 20,000 pediatric patient visits per year in the program’s primary ED.

Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for pediatric emergency 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 pediatric emergency 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
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➤ 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 pediatric emergency 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 pediatric emergency 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 pediatric emergency medicine. 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 pediatric emergency medicine**

**Basic education:** MD or DO  
**Minimal formal training:** Successful completion of an ACGME- or AOA-accredited residency in pediatrics or emergency medicine, followed by successful completion of an accredited fellowship in pediatric emergency medicine (plus advanced cardiac life support, advanced pediatric life support, or pediatric advanced life support certification) and/or current subspecialty certification or active participation in the examination process (with achievement of certification within \([n]\) years) leading to subspecialty certification in pediatric emergency medicine by the ABP or the ABEM.  
**Required current experience:** Active practice in an ED providing pediatric emergency medicine services with a census equal to or exceeding 10,000 patient visits annually, reflective of the scope of privileges requested, in 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 pediatric emergency medicine**

Core privileges for pediatric emergency medicine include the ability to assess, evaluate, diagnose, and initially treat patients from infancy to young adulthood who present in the ED with any symptom, illness, injury, or condition. Pediatric
Pediatric emergency medicine physicians should provide immediate recognition, evaluation, care, stabilization, and disposition in response to acute illness and injury. Privileges include the performance of history and physical examinations, the ordering and interpretation of diagnostic studies (including laboratory, diagnostic imaging, and electrocardiographic examinations), and the administration of medications normally considered part of the practice of emergency medicine. Privileges do not include admitting privileges, long-term care of patients on an inpatient basis, or the performance of scheduled elective procedures. The core privileges in this specialty include the procedures on this procedures list and such other procedures that are extensions of the same techniques and skills.

- Performance of history and physical exam
- Abscess incision and drainage
- Administration of sedation and analgesia per hospital policy
- Airway management and intubation
- Anesthesia via IV (upper extremity, local, and regional)
- Anoscopy
- Arterial puncture and cannulation
- Arthrocentesis
- Bladder decompression and catheterization techniques
- Blood component transfusion therapy
- Burn management, including escharotomy
- Cardiac pacing (external)
- Cardioversion/defibrillation
- Central venous catheterization
- Cricothyrotomy (translaryngeal ventilation)
- Conversion of supraventricular tachycardia
- Dislocation/fracture reduction/immobilization techniques, including splint and cast applications
- Electrocardiography interpretation
- Endotracheal intubation techniques
- Gastrointestinal decontamination (emesis, lavage, charcoal)
- Hernia reduction
- Intraosseous access
- Irrigation and management of caustic exposures
- Laryngoscopy (direct and indirect)
- Lumbar puncture
- Management of epistaxis
- Nail trephine techniques
- Nasal cautery/packing
- Nasogastric/orogastric intubation
- Ocular tonometry
- Open cardiac massage
- Oxygen therapy
- Paracentesis
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➤ Pericardiocentesis
➤ Peripheral venous cutdown
➤ Peritoneal lavage
➤ Preliminary interpretation of imaging studies
➤ Rapid sequence intubation
➤ Removal of foreign bodies from the nose, eye, and ear, and soft instrumentation/irrigation of skin or subcutaneous tissue
➤ Repair of lacerations
➤ Resuscitation
➤ Slit lamp used for ocular exam
➤ Spine immobilization
➤ Thoracentesis
➤ Thoracostomy tube insertion
➤ Thoracotomy (open for patient in extremis)
➤ Tracheostomy
➤ Wound debridement

Special noncore privileges in pediatric emergency 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 emergency (bedside) ultrasound.

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 pediatric emergency medicine, the applicant must have current demonstrated competence and an adequate volume of experience 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 pediatric emergency medicine should be required.

For more information

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