Hackensack Meridian *Health*
Jersey Shore University Medical Center

Acupuncture

Delineation of Privileges

Applicant's Name: _____

Required Qualifications	
Education/Training	Completion of Acupuncture training program approved by the NJ Board of Medical Examiners Or Completion of an acupuncture training program that qualifies the application for National Certification in Acupuncture and/or Chinese Herbology provided by the National Certification Commission of Acupuncture and Oriental Medicine (MCCAOM)
Certification	Current National Certification in Acupuncture and/or Chinese Herbology provided by the National Certification Commission of Acupuncture and Oriental medicine (NCCAOM)
Clinical Experience (Initial)	Applicant must provide documentation of provision of acupuncture services representative of the scope and complexity of the privileges requested during the previous two years (waived for applicants who have completed training during the previous two years).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the past 24 months.

Request		Dept Chair Rec
	Interview patient for medical history; perform patient assessment	
	Develop Acupuncture plan	
	Provide patient/family instructions and education	
	Use of needles, electric stimulators and heat in treatment	
	Use of trigger point and oriental adjustment techniques	

Acknowledgement of Applicant

I have requested only those privileges for which by education, training and current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Jersey Shore University Medical Center.

I agree to be bound by the organization rules and regulations and/or policies and procedures related to the exercise of any privileges granted to me.

_____ _____

Practitioner Signature Date

Department Chair Recommendation

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:

Privileges	Condition/Modification/Deletion/Explanation

Department Chair recommendation – proctoring requirements

_____

Department Chair - Print

_____ _____

Department Chair – Signature Date