Clinical Activity Logs Guideline

When granting clinical privileges, an organization must ensure that an applicant has current demonstrated competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested. The current competency period is typically within the last two years although some privilege criteria may be specific to the last twelve months.

As part of the processing of a credentials and privilege application, the Credentialer will ask for documentation to support the privileges requested. This may include clinical activity logs.

The following are some examples of documentation that may be submitted for clinical activity logs:

- Listing of patients seen (names should be erased) and procedures performed with dates
- Performance data from primary hospital or practice location
- A “To Whom It May Concern” memo on primary hospital or practice location letterhead indicating total number of patient encounters/procedures within specific timeframe
- Listings generated from billing data which includes patient/procedure activity
- Residency Training Logs

If you are unsure of where to obtain such documentation, contact your Practice Manager at your most recent practice location or Medical Staff office of your primary hospital. Also many hospital Quality Departments are able to run data reports which provide valuable information.