



**ALLIED HEALTH PROFESSIONAL STAFF  
EMERGENCY DEPARTMENT  
NURSE PRACTITIONER  
(Advanced Practice Registered Nurse)**

Name: \_\_\_\_\_ Credentials: \_\_\_\_\_

**Qualifications:** Licensed registered nurse in the State of Louisiana having completed a master's level degree in a specialty area in nursing holding appropriate credentials as an APRN. Post-graduate training requirements include: Trauma Nursing Core Course (TNCC), Pediatric Advanced Life Support (PALS), Advanced Cardiac Life Support (ACS), and current certification or active participation in the examination process leading to certification by the ANCC or equivalent board.

The applicant shall also satisfy the requirements of the Louisiana Administrative Code of Professional & Occupational Standards, Title 46, Part XLVII, Subpart 2, "Registered Nurses", Chapter 45, Subset 4507, and function within the Scope of Practice for Advanced Practice Registered Nurses as promulgated under Subset 4513 and 4515.

**Delineation of Clinical Privileges:** Notwithstanding the Louisiana State Board of Nursing, Legal Standards of Nursing Practice Act, all clinical privileges are to be reflective of the Collaborative Practice Agreement entered into between Teche Regional Medical Center, The Schumacher Group, and the APRN.

**Supervision:** The Advanced Practice Registered Nurse (APRN) will function under the direct supervision of the Emergency Department Physician (EDP) carrying out protocols established by The Schumacher Group and Hospital as approved by the Medical Executive Committee. The EDP retains ultimate responsibility for directing the specific course of medical treatment. Any medical situation or condition that arises that is not addressed by a protocol or other directive is to be referred immediately to the supervising Emergency Department Physician.

The phrase "under the direction of a physician" shall be construed as a periodic evaluation and follow-up of the medical regime. This includes an evaluation of the patient's condition during the course of the emergency room visit, up and until discharge, placement, or transfer. Direction shall be pursuant to the Collaborative Practice Agreement consistent with the patient's level of acuity, classification or designation, but not limited to: (a) an EDP readily available for consultation with the Nurse Practitioner at all times; (b) an EDP readily available for consultation with the patient upon request of any patient under the care of a physician-directed health care team member or APRN.

(R)= Recommended as Requested (A)=Approved as Requested (C)=Recommended with Condition(s) (N)=Not Recommended

Requested		CORE PRIVILEGES Within the scope of practice previously described, the Emergency Department APRN may perform the following functions:				
Yes	No					
		<b>EXAMINATION AND TREATMENT EMERGENCY MEDICAL SCREENING:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Take pertinent histories relevant to patients' complaint and presentation (to be countersigned by supervising physician within 24 hours or as soon as possible)</li> <li><input type="checkbox"/> Perform general medical screening exam</li> <li><input type="checkbox"/> Establish medical diagnoses and determine a plan of care</li> </ul>	(R)	(A)	(N)	(C) Condition/Reason(s)
		<b>MEDICAL ORDERS/PROTOCOLS:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Initiate established protocols for the medical treatment of patients with minor illnesses and injuries</li> <li><input type="checkbox"/> Order and interpret results of routine laboratory tests, including by not limited to CBC, Blood chemistries, HCG, wet preps, UA and urine C&amp;S.</li> <li><input type="checkbox"/> Order routine radiological studies</li> <li><input type="checkbox"/> Order and interpret results of arterial blood gases</li> </ul>				It is expected that the APRN will use sound professional judgment and consult with the EDP anytime there are findings in the H&P suggestive of a serious or potentially serious medical condition.

		<p><b>ROUTINE INTERVENTIONS:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Incision and drainage of superficial abscesses</li> <li><input type="checkbox"/> Perform acts of diagnosis and treatment as determined by established, written protocols between NP's scope of knowledge and training and the supervising physician's scope of clinical privileges <b>(*refer to collaborative practice agreement)</b></li> <li><input type="checkbox"/> Perform physical examination including rectal and pelvic examination</li> <li><input type="checkbox"/> Prescribe or alter medications from a limited formulary, including controlled substances, and other treatments for selected medical problems as agreed upon in written protocols with the supervising physician (must be countersigned by supervising physician within 24hrs. or as soon as possible) <b>*prescriptive authority must be granted pursuant to LAC 46:XLVII.3341</b></li> <li><input type="checkbox"/> Suture lacerations (after evaluation by supervising EDP)</li> <li><input type="checkbox"/> Transcribe orders for review and countersignature of physician within 24 hours or as soon as possible.</li> </ul>				
		<p><b>PATIENT EDUCATION:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Provide patient healthcare teaching and counseling relevant to presenting problem.</li> <li><input type="checkbox"/> Provide discharge instructions and document summarization (to be countersigned by EDP)</li> </ul>				
<p><b>**Duties not allowed: Spinal taps, Paracentesis, Thoracentesis, Bone marrow aspiration or biopsy**</b></p>						

In making application for appointment/reappointment to the Allied Health Professional Staff of Teche Regional Medical Center, the Emergency Department Medical Director and I agree to the following:

1. We have read the Medical Staff Bylaws, Rules and Regulations concerning Allied Health Professionals, and agree to abide by these rules and regulations and policy & procedures of Teche Regional Medical Center.
2. The physician or employing group assumes full responsibility for any services provided by the applicant and agrees to indemnify and hold harmless Teche Regional Medical Center from any liability to anyone including patients and third parties, arising from any act or omission or commission of the AHP applicant.
3. The applicant fully understands that any significant misstatements in, or omission from this application constitute cause for denial of appointment or cause for denial of privileges and immediate removal from the Allied Health Professional Staff.
4. All information submitted in this application is true to the best of applicant's knowledge.
5. The applicant's signature certifies that he/she is not dependent upon drugs or alcohol and based upon his/her last physical examination, his/her mental and physical capabilities are fully adequate for the performance of the duties and privileges requested.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature of Supervising Physician  
or ED Medical Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Requested clinical privileges reviewed and recommend as indicated above.

\_\_\_\_\_  
Signature of Service or Department Chairman

\_\_\_\_\_  
Date

**Board of Trustees' Decision**

*Teche Regional Medical Center's Board of Trustees*

- Does  Does not grant clinical privileges as requested  
(if "does not" grant, give reasons in letter to the applicant with a copy of privilege list)

\_\_\_\_\_  
Secretary, Board of Trustees

\_\_\_\_\_  
Date



**HEALTH STATEMENT**

**TO CHIEF OF SERVICE / CHIEF OF STAFF**

1. I HEREBY CERTIFY THAT I POSSESS THE NECESSARY COGNITIVE AND MOTOR SKILLS TO SAFELY PERFORM ALL PRIVILEGES REQUESTED AND DECLARE MYSELF TO BE FREE FROM ANY CONDITION, ILLNESS, OR INFECTIOUS DISEASE THAT COULD COMPROMISE PATIENT CARE OR MY ABILITY TO PERFORM THE PRIVILEGES REQUESTED.

YES  NO

2. IF NO, DO YOU HAVE A PHYSICAL OR MENTAL CONDITION OR ILLNESS (INCLUDING ANY CHEMICAL OR ALCOHOL DEPENDENCY) WHICH COULD AFFECT YOUR ABILITY TO EXERCISE THE CLINICAL PRIVILEGES REQUESTED WITHOUT SPECIAL ACCOMMODATIONS IN ORDER FOR YOU TO EXERCISE THE PRIVILEGES REQUESTED SAFELY AND COMPETENTLY? TO ANSWER THIS QUESTION APPROPRIATELY, PLEASE REPORT ANY CONDITION WHICH IS, OR MAY BE INFECTIOUS, COULD AFFECT MOTOR SKILLS, COGNITIVE ABILITY OR JUDGMENT, OR COULD POTENTIALLY ADVERSELY AFFECT YOUR ABILITY TO CARE FOR PATIENTS OR TO INTERACT APPROPRIATELY WITH OTHER CAREGIVERS.

YES  NO

If yes, please explain:

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3. HAVE YOU TESTED POSITIVE FOR THE TUBERCULIN SKIN TEST?  YES  NO

If yes, please give date of positive skin test. \_\_\_\_\_

If no, when was your last PPD test? \_\_\_\_\_

REGARDLESS OF HOW THIS QUESTION IS ANSWERED, THE APPLICATION WILL BE PROCESSED IN THE USUAL AND CUSTOMARY MANNER. IF YOU HAVE ANSWERED THIS QUESTION AFFIRMATIVELY AND ARE FOUND TO BE PROFESSIONALLY QUALIFIED FOR MEDICAL STAFF APPOINTMENT AND CLINICALLY COMPETENT TO PERFORM THE CLINICAL PRIVILEGES REQUESTED, YOU WILL BE GIVEN AN OPPORTUNITY TO MEET WITH THE EXECUTIVE COMMITTEE TO DETERMINE WHAT ACCOMMODATIONS, IF ANY, ARE NECESSARY TO ALLOW YOU TO PRACTICE SAFELY.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CHIEF OF SERVICE

\_\_\_\_\_  
DATE