



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

Name: _____ Credentials: _____

Supervising Physician: _____ Specialty: _____

Teche Regional Medical Center Advanced Practitioner of Nursing applicants shall be licensed as registered nurses in the State of Louisiana and have completed a master's level degree in a specialty area in nursing. 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 (attached).

The nurse practitioner will function under the direct supervision of the sponsoring physician/group carrying out protocols established by the sponsoring physician/group as approved by the Medical Executive Committee. The physician 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 physician directive is to be referred immediately to the directing 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 the patient's condition during the course of the medical treatment and the patient's medical outcome. Directions shall be deemed to include, but not limited to: (a) a physician's being readily available for consultation with the primary nurse associate; (b) a physician's being readily available for consultation with the patient upon the request of any patient under the care of a physician-directed health care team.

The APRN who has prescriptive authority, engages in medical diagnosis and management shall have, and produce, a collaborative practice agreement.

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

Requested		CORE PRIVILEGES				
Yes	No	[Please indicate which procedure/privilege you intend on performing at this facility]	(R)	(A)	(N)	(C) Condition/Reason(s)
		ACCESS TO MEDICAL RECORDS: <input type="checkbox"/> Dictate/Write History and Physical (to be countersigned by supervising physician within 24 hours) <input type="checkbox"/> Dictate/Write Progress Notes (to be reviewed and countersigned by supervising physician within 24 hours) <input type="checkbox"/> Dictate Discharge Summaries (to be countersigned by physician within 24 hours)				
		MEDICAL HISTORY AND PHYSICAL: <input type="checkbox"/> Interview patient for Medical History <input type="checkbox"/> Perform general screening exam <input type="checkbox"/> Perform physical exam and evaluations				
		MEDICAL ORDERS/PROTOCOLS: <input type="checkbox"/> Initiate established protocols approved by the Medical Executive Committee for medical treatment and transcribe standing orders (to be countersigned by physician within 24 hours for inpatient and emergency room orders, 72 hours for outpatient orders) <input type="checkbox"/> Diagnostic tests and procedures: Order tests and special procedures as follows: (under the direction of the sponsoring physician) <input type="checkbox"/> Rounds on patients (not to substitute for physician's daily rounds)				

		<p>Routine Interventions as authorized by protocols approved by the Medical Executive Committee:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Administer injections <input type="checkbox"/> Administer and start IV fluids <input type="checkbox"/> Administer local infiltrative anesthetics <input type="checkbox"/> Apply, remove, and change dressings and bandages <input type="checkbox"/> Apply splints and temporary casts <input type="checkbox"/> Heimlich maneuver <input type="checkbox"/> Incision and drainage of superficial abscesses <input type="checkbox"/> Insertion and change foley catheters <input type="checkbox"/> Insertion nasogastric tubes <input type="checkbox"/> Obtain appropriate cultures (throat, wound, urine) <input type="checkbox"/> Obtain venous blood samples/culture <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 (*collaborative agreement required) <input type="checkbox"/> Perform physical examination including rectal and pelvic examination <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.) <i>*prescriptive authority granted pursuant to LAC 46:XLVII.3341</i> (*collaborative agreement required) <input type="checkbox"/> Remove sutures/staples <input type="checkbox"/> Suture lacerations (after evaluation by supervising physician) <input type="checkbox"/> Transcribe orders for review and countersignature of physician within 24 hours for inpatient and emergency room orders, 72 hours for outpatient orders. 				
		<p>PATIENT EDUCATION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Provide information relative to: exercise, diet, tobacco and alcohol intake, range of motion, use of crutches or walker, activities of daily living. <input type="checkbox"/> Develop individualized patient teaching plans based on patient needs. 				
<p>**Duties not allowed: Spinal taps, Paracentesis, Thoracentesis, Bone marrow aspiration or biopsy**</p>						

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

1. The supervising physician and applicant 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 who employs or contracts with the AHP 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 to the best of his/her knowledge, 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

Date

Date

**Nurse Practitioner
Core Privileges**

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:

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