



Core Privileges

EMERGENCY MEDICINE

Qualifications: M.D. or D.O. having successfully completed an accredited ACGME/AOA residency program with current certification or active participation in the examination process leading to certification by the American Board of Medical Specialties or the American Board of Osteopathic Specialists in emergency medicine or primary care specialty; with evidence of the following:

- Current certification in Advance Cardiac Life Support
- Current certification in Advanced Trauma Life Support
- Current certification in Pediatric Life Support

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

Requested						
Yes	No	CORE PRIVILEGES:	(R)	(A)	(N)	(C) Condition/Reason(s)
		<p>Privileges to assess, evaluate, diagnose, and provide initial treatment to any patient presenting to the emergency department with any symptom, illness, injury, or condition; provide services necessary to ameliorate minor illnesses or injuries and determine if additional follow-up care is needed; stabilize patients with major illnesses or injuries for inpatient admission or transfer.</p> <p>Core privileges also include but are not limited to the following:</p> <ul style="list-style-type: none"> ▪ Performing historical and physical examinations, including ordering and interpreting diagnostic studies; ▪ Administer appropriate medications; ▪ Requesting consultations and technical procedures to be performed by other physicians and qualified consultants/technicians; ▪ Managing the EMS medical coordination of the acutely ill or injured patient. <p>[Note: Privileges do not include long-term care of patients on an inpatient basis, or admitting or performing scheduled elective procedures; with the exception of procedures performed during routine emergency room follow-up visits.]</p>				
		PROCEDURE LIST				
		<i>The following procedures are included in emergency medicine core privileges (unless specifically not requested):</i>				
		Arterial puncture				
		Arthrocentesis				
		Paracentesis				
		Pericardiocentesis				
		Thoracocentesis				
		Electrocardiography interpretation				
		Cardioversion				
		Defibrillation				
		Excision of lesions				
		Incision & drainage abscess				
		Laceration repair simple/complex				

		Needle & tube thoracostomy				
		Endotracheal intubation				
		Interosseous line insertion				
		Cricothyroidotomy				
		Suprapubic tap				
		Muscle & tendon repair				
		Injection of joints				
		Local anesthesia				
		Spinal tap				
		Regional nerve blocks				
		Neuromuscular blockade				
		Cardiac massage (open/closed)				
		Cardiac pacing				
		Fluoroscopy				
		Contrast injection for imaging				
		Moderate Conscious Sedation				
		Cystourethrogram				
		Tonometry				
		Nasogastric/orogastric intubation				
		Peritoneal lavage				
		Bladder catheterization				
		Gastric lavage				
		Slit lamp examination				
		Precipitous newborn deliveries				

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified and competent to perform and for which I wish to exercise at Teche Regional Medical Center.

I further understand that I shall, in an emergency, be authorized to treat any medical disease and/or perform any medical and/or surgical procedure(s) that are necessary. An emergency, for these purposes, is defined as any situation in which any delay in administering treatment would result in serious harm to the patient or an immediate threat to the life of the patient.

Signature of Applicant

Date

Printed Name

Requested privileges reviewed and recommended as indicated above.

Signature of Service or Department Chair

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