



**CORE PRIVILEGES  
INTERNAL MEDICINE SERVICE**

Internal Medicine Physicians provide long-term, comprehensive care managing both common and complex illness of adolescents, adult patients, and the elderly. Internists are trained in the diagnosis and treatment of cancer, infections, and disease affecting the heart, blood, kidneys, and joints, as well as the digestive, respiratory, and vascular systems; providing patient care for acute illnesses or chronic disease processes in the hospital's inpatient and ambulatory care settings.

Internists are trained in the essentials of primary care internal medicine, which incorporates an understanding of disease prevention, wellness, substance abuse, mental health and effective treatment of common problems of the eyes, ears, skin, nervous system, and reproductive organs. Internists also serve as consultants and resource managers familiar with the science of clinical epidemiology, and assist in the evaluation and management of all aspects of illness—biomedical and psychosocial—in the whole patient.

**QUALIFICATIONS:**

- MD or DO with successful completion of a three-year ACGME/AOA-accredited residency/fellowship program in internal medicine
- Current certification or active participation in the examination process leading to certification in internal medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.
- Documentation or attestation of the management of internal medicine problems for at least 100 inpatients or outpatients as the attending physician during the past two years.

(√)= Requested      (A)=Recommended as Requested      (C)=Recommended with Conditions      (N)=Not Recommended

(R)	CORE PRIVILEGES:	(A)	(C)	(N)	Condition/Reason(s)
	Privileges to admit, (to include performance of history and physical examinations to be completed within 24-hours of admission), work-up, diagnosis, manage, and provide non-surgical treatment or consultative services to patients above the age of 12 admitted with both common and complex illnesses.  Core Privileges include the performance of the following procedures with an understanding of their indications, limitations, contraindications and complications, and interpreting their results, <b><u>unless specifically not requested:</u></b>				Internal Medicine Physicians are expected to request consultation when:  a) diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness; b) unexpected complications arise which are outside this level of competence; c) specialized treatment of procedures are contemplated with which they are not familiar.
	Advanced cardiac life support				
	Arterial and venous puncture				
	Arterial line placement, percutaneous				
	Arthrocentesis, large joint				
	Central venous line placement				
	Electrocardiograms (ECG) Interpretation				
	Endotracheal Intubation, emergent				
	I & D cutaneous abscess				
	Lumbar puncture				
	Nasogastric intubation				
	Paracentesis (abdominal)				
	Pulmonary Function				
	Removal of non-penetrating corneal foreign body, foreign body from conjunctival sac, ear, nose, skin				
	Respirator Management				

<input type="checkbox"/>	Skin testing (allergy and cell-mediated) interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Skin biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Spinal Tap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Suture minor lacerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Therapeutic injection, large joint, small joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Thoracentesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SPECIAL PROCEDURES:** Applicants seeking (or renewing) special privileges outside of the core must demonstrate to the Credential/MEC/Board that they are competent to perform the privilege(s) requested by any of the three methods, if no criteria is established: 1) have performed the procedure(s) in high enough volume within the past 2-years that any quality trends might be detectable; 2) have references attesting to current competency; or 3) have a proctor attest to clinical competency.

(R)	SPECIAL PROCEDURES (INVASIVE)	(A)	(C)	(N)	Condition/Reason(s)
<input type="checkbox"/>	Pericardiocentesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Pulmonary artery catheterization (Swan-Ganz)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>*Intensive Care Unit only</i>
<input type="checkbox"/>	<b>BIOPSY AND EXCISION:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Bone Marrow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>ENDOSCOPIC PROCEDURES: (must indicate/write with or without biopsy)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>* CME documentation required relating to gastrointestinal endoscopy in addition to continuing clinical activity with the requested procedure</i>
<input type="checkbox"/>	Bronchoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Dudenoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Endoscopic Retrograde Cholangiopancreatography (ERCP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Esophagoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Gastroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<b>OTHER PROCEDURES (NON-INVASIVE):</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Ventilator management in ICU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>*treatment plan should be re-evaluated for consult or transfer if patient cannot be extubated after 72 hours</i>
<input type="checkbox"/>	<b>MODERATE SEDATION:</b> (consistent with hospital's sedation policy)  <input type="checkbox"/> Fentanyl <input type="checkbox"/> Naxolone (Narcan) <input type="checkbox"/> Morphine <input type="checkbox"/> Flumazenil (Romazicon) <input type="checkbox"/> Meperidine (Demerol) <input type="checkbox"/> Chloral Hydrate (Noctec) <input type="checkbox"/> Diazepam (Valium)            Other: _____ <input type="checkbox"/> Midazolam (Versed)            _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>*must be ACLS certified, pass proficiency exam or have documentation of training from residency program</i>

I attest that I have managed internal medicine problems of at least 100 patients admitted to my service during the past two years and have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise at Teche Regional Medical Center.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**I have reviewed the requested clinical privileges and supporting documentation and recommended the privileges as indicated above.**

\_\_\_\_\_  
Signature of Service or Department Chair

\_\_\_\_\_  
Date

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**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