



Ville Platte—Eunice

REQUEST FOR CLINICAL PRIVILEGES & RECORD OF PRIVILEGES GRANTED

1. NAME \_\_\_\_\_

2. Areas of Practice

Attached is my request(s) for those clinical privileges in the following areas of practice for which by training and experience I have current competence and which I wish to exercise at Mercy Regional Medical Center and /or Acadian Medical Center (A campus of Mercy Regional Medical Center).

- \_\_\_Anesthesiology \_\_\_Dermatology \_\_\_Orthopedic/Traumatic
\_\_\_Emergency Medicine \_\_\_Dental \_\_\_Otolaryngological/Neck
\_\_\_Medicine \_\_\_Neurology \_\_\_Plastic/Maxillofacial/Oral
\_\_\_Surgery \_\_\_Abdominal \_\_\_Rectal
\_\_\_Nuclear Medicine \_\_\_Breast \_\_\_Thoracic
\_\_\_Obstetrics \_\_\_Gynecological \_\_\_Urological
\_\_\_Pathology \_\_\_Neurosurgical \_\_\_Vascular
\_\_\_Pediatrics \_\_\_Ophthalmic \_\_\_Other
\_\_\_Psychiatry \_\_\_Family/General Practice \_\_\_Podiatry
\_\_\_Radiology \_\_\_Optometry \_\_\_Physician Assistant

\_\_\_Special Procedures – Non-Specialty Specific (K-6)

3. Subject to Consultation Requirements and Other Policies

I understand that in exercising any clinical privileges granted, I am constrained by relevant Hospital and Medical Staff policies requiring consultations for difficult diagnoses, conditions of extreme severity, and procedures/conditions which are beyond my area of specialization and expertise, by Hospital policies concerning the types of patients for whom it does not have appropriate resources (facilities, equipment or personnel) to treat except on an emergency basis, and by such special policies as may from time to time be adopted.

4. Emergency Situations

I also understand that it is not necessary to request emergency clinical privileges; that an emergency is deemed to exist whenever serious permanent harm or aggravation of injury or disease is imminent; or the life of the patient is in immediate danger, and any delay in administering treatment could add to that danger; that in such emergency I am authorized and will be assisted to do everything possible to save the patient’s life or to save the patient from serious harm, to the degree permitted by my license but regardless of department affiliation, staff category or level of privileges; and that if I provide services to a patient in an emergency, I am obligated to utilize appropriate consultative assistance when available and to arrange for appropriate follow-up care.

5. Signature \_\_\_\_\_ Date \_\_\_\_\_

**6. Conditions/Exceptions**

The following clinical privileges have been approved by the Board of Trustees with the following conditions or exceptions:

<b>PRIVILEGE</b>	<b>CONDITION/EXCEPTION</b>

**7. APPROVALS:**

**SERVICE CHIEF** \_\_\_\_\_ **DATE** \_\_\_\_\_

**MEC** \_\_\_\_\_ **DATE** \_\_\_\_\_

**BOARD** \_\_\_\_\_ **DATE** \_\_\_\_\_



Ville Platte—Eunice

Application for Clinical Privileges
Clinical Privileges Delineation Form

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

Sponsoring Physician: \_\_\_\_\_

Category: Certified Registered Nurse Anesthetist

Type of Request: [ ] Initial [ ] Renewal

Please check the procedures for which you are making application:

- Preanesthetic assessment, Requesting laboratory/diagnostic studies, Preanesthetic medication, General anesthesia and adjuvant drugs, Cardiopulmonary resuscitation management, Perianesthetic invasive and noninvasive monitoring, Tracheal intubation/extubation, Mechanical ventilation/oxygen therapy, Fluid, electrolyte, acid-base management, Blood, blood products, plasma expanders, Peripheral intravenous/arterial catheter placement, Central venous catheter placement, Acute and chronic pain therapy, Post anesthesia care/discharge, External Jugular Catheterization, Conscious and deep sedation techniques, Perianesthesia management of patient using accessory drugs or fluids, Other, ADULT (ASA Risk 5, 4, 3, 2 & 1), Regional anesthesia techniques (Subarachnoid, Epidural, Caudal, Upper Extremity, Lower Extremity, Diagnostic and therapeutic nerve blocks, Local infiltration, Topical, Periocular block, Transtracheal, Intracapsular, Intercostal, Bier block, Ankle block, Intravenous Agents, Other), PEDIATRIC & NEWBORN (ASA Risk 5, 4, 3, 2 & 1)

I am mentally and physically capable of performing the privileges which I have requested:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (please print) \_\_\_\_\_



**Ville Platte/Eunice**

\_\_\_\_\_  
PHYSICIAN NAME

\_\_\_\_\_  
LICENSE NUMBER

**MEDICARE**

“Notice to Physicians: Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal Funds, maybe subject to fine, imprisonment, or civil penalty under applicable Federal Laws.”

I, \_\_\_\_\_, certify that I have received the above statement.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CHAMPUS**

“Notice to Physicians: Champus payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal Funds, maybe subject to fine, imprisonment, or civil penalty under applicable Federal Laws.”

I, \_\_\_\_\_, certify that I have received the above statement.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



Ville Platte/Eunice

**STATEMENT OF PHYSICAL HEALTH**

**Examining Physician**

I do hereby certify that I have examined \_\_\_\_\_ and consider this health care professional to be in satisfactory physical and mental health and able to carry out the duties necessary in the performance of this individual's profession. I have determined that this health care professional is free from any health impairment which is of potential risk to patients or might interfere with the performance of his duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

Any limitations or restrictions on this health care professional are as follows:

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\_\_\_\_\_  
Signature of Examining Physician

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

\_\_\_\_\_  
Date

**Applicant**

As a member of the Medical Staff or Allied Health Staff of Mercy Regional Medical Center and/or Acadian Medical Center (A campus of Mercy Regional Medical Center) it is recommended that you have an annual TB screening test and present the test results to the Credentialing Department of Mercy Regional Medical Center. This test is provided for you free of charge. **If you have had a TB test done within the past year, send a copy of the results with your completed application.**

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