



**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).

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anesthesiology     | <input type="checkbox"/> Dermatology             | <input type="checkbox"/> Orthopedic/Traumatic       |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Dental                  | <input type="checkbox"/> Otolaryngological/Neck     |
| <input type="checkbox"/> Medicine           | <input type="checkbox"/> Neurology               | <input type="checkbox"/> Plastic/Maxillofacial/Oral |
| <input type="checkbox"/> Surgery            | <input type="checkbox"/> Abdominal               | <input type="checkbox"/> Rectal                     |
| <input type="checkbox"/> Nuclear Medicine   | <input type="checkbox"/> Breast                  | <input type="checkbox"/> Thoracic                   |
| <input type="checkbox"/> Obstetrics         | <input type="checkbox"/> Gynecological           | <input type="checkbox"/> Urological                 |
| <input type="checkbox"/> Pathology          | <input type="checkbox"/> Neurosurgical           | <input type="checkbox"/> Vascular                   |
| <input type="checkbox"/> Pediatrics         | <input type="checkbox"/> Ophthalmic              | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Psychiatry         | <input type="checkbox"/> Family/General Practice | <input type="checkbox"/> Podiatry                   |
| <input type="checkbox"/> Radiology          | <input type="checkbox"/> Optometry               | <input type="checkbox"/> 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
CARDIOLOGY CORE PRIVILEGES

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

To be eligible to request clinical privileges utilizing this form, the following minimum threshold criteria must be met:

Basic Education: M.D. or D.O. received from an accredited medical school.

Minimal Formal Training: Successful completion of an approved residency training program in internal medicine and completion of a cardiology fellowship.

Cardiology Core Privileges: Privileges include admission, EKG interpretation, Holter monitor interpretation, exercise stress testing, defibrillator evaluation, echocardiography interpretation, countershock and synchronized cardioversion. Requested \_\_\_\_\_ Granted \_\_\_\_\_

Special Requests: The applicant must provide documentation of current competence to request these privileges:

- Coronary diagnostic angiography to include left heart catheterization, right heart catheterization, and ventriculogram.
Insertion of transvenous temporary pacemaker.
Implantation of permanent pacemaker.
Diagnostic peripheral angiography (extremities)
Diagnostic carotid and cerebral angiography
Inferior vena cava filter placement
Pulmonary angiography
Therapeutic angiography (i.e., thrombolysis)
Interventional peripheral (angioplasty, stents, thrombolysis)
Interventional coronary
Interventional carotid
Interventional intracranial (thrombolysis for stroke, angioplasty, stents)
Endomyocardial biopsy
Coronary stent placement
Intra-aortic balloon pump (IABP)
Embolization, non-neurologic
Diagnostic venography
Other: \_\_\_\_\_ Requested \_\_\_\_\_ Granted \_\_\_\_\_

Emergency Privileges: In the case of an emergency, any medical staff appointee is authorized to do anything possible to save a patient's life or save a patient from serious harm. A practitioner exercising such emergency privileges is obligated to arrange for all consultative assistance deemed necessary and to arrange for appropriate follow-up.

I hereby certify that I possess the necessary skill and expertise to justify granting of clinical privileges in those areas requested. I understand that in making this request, I am bound by the applicable bylaws and policies of the hospital and hereby stipulate that I meet the threshold criteria for each request.

Applicant Signature

Date



**Ville Platte/Eunice  
CARDIOLOGY PRIVILEGES**

**Staff Category (circle one): Active, Courtesy, Consulting, Temporary**

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

REQUESTED	PROCEDURE/DIAGNOSIS
	Left Heart Catheterization, Ventriculography
	Right Heart Catheterization
	Selective angiography of coronary arteries, venous bypass grafts, internal mammary arteries
	Aortic angiography including root, arch, thoracic and abdominal aorta with distal runoff
	Selective angiography of subclavian, brachial, carotid, vertebral, iliac, renal, femoral, popliteal and pulmonary vessels
	Selective angiography of AV fistulas, shunts, and grafts
	Intravenous contrast use including selective venography
	Insertion of Intra-Aortic Balloon pumps/counterpulsation
	Endomyocardial biopsy
	Fluoroscopy & Interpretation
	Angioplasty including coronary (native vessel and grafts), venous, iliac, SFA, renal, femoral, and popliteal vessels <i>(emergent only for coronary vessels)</i>
	Angioplasty of AV grafts with/without thrombectomy
	Stenting including coronary (native vessels & grafts), venous, iliac, SFA, renal, femoral and popliteal vessels <i>(emergent only for coronary vessels)</i>
	Thrombolysis, intracoronary, intravenous, and trans-catheter infusions

## CARDIOLOGY PRIVILEGES

REQUESTED	PROCEDURE/DIAGNOSIS
	Deployment and use of closure devices including angioseal, Vasoseal and Perclose
	Ergonovine provocation test
	EKG interpretation
	Tilt table evaluation
	Overdrive pacing for cardioversion
	Comprehensive EP studies and left atrial/ventricular recordings, including pacing and programmed stimulation studies, induction of arrhythmias, both with/without IV drugs
	Intracardiac mapping, both atrial and ventricular
	Intracardiac catheter ablation procedures including AV node, slow pathway of the AV node, atrial flutter, atrial/ventricular foci, and accessory pathways
	Esophageal pacing/recording
	Temporary pacemaker placement, transvenous
	Dual/Single chamber permanent pacemaker implantation/explantation, lead assessment, pacemaker programming/analysis/interpretation
	Dual/Single chamber ICD implantation/explantation, lead assessment, generator testing, defibrillation threshold measurements, ICD programming/analysis/interpretation including non-invasive testing
	Pacemaker/ICD lead explantation, repositioning of leads
	Loop recorder implant/explant, programming/interpretation
	CPR

## CARDIOLOGY PRIVILEGES

REQUESTED	PROCEDURE/DIAGNOSIS
	Stress testing, both pharmacological/exercise with/without nuclear/echo imaging
	Performance and interpretation of transesophageal/transthoracic echocardiography including contrast studies, Doppler, 2D and M-mode

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

\_\_\_\_\_  
Date



**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

Reappointment Activity/Quality Verification Form

I, (print) \_\_\_\_\_, understand that to qualify for reappointment to the Medical Staff of Mercy Regional Medical Center/Acadian Medical Center (A campus of Mercy Regional Medical Center, I must provide evidence of a minimum of 24 patient activities (i.e., admissions/consultations/surgeries/procedures) during the past 2 year period to be able to demonstrate current clinical competence.

If I have not met the minimum case requirement at Mercy Regional Medical Center, I understand it is my responsibility to obtain appropriate verification from the hospital where I more actively practice and can provide evidence of a minimum of 24 patient activities (i.e., admissions/consultations/ surgeries/procedures) during the past 2 year period for the purpose of demonstrating current clinical competence. I hereby consent to the release of the requested information below for purposes of appointment/reappointment to the Medical Staff of Mercy Regional Medical Center.

Appropriate verification is:

- Completion of the lower section of this form by a hospital’s representative which must be returned directly from the Facility completing the information via mail or facsimile 505-346-0829 or 337-580-7729.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

I, (print) \_\_\_\_\_, verify that the above named physician has had the following patient activities at this facility during the past two (2) year period.

- Upon request of the above named practitioner, the following information is provided for the past 2 year period:

Number of admissions \_\_\_\_\_ Number of consultations \_\_\_\_\_ Number of procedures \_\_\_\_\_

Number of deaths \_\_\_\_\_ Infection rate \_\_\_\_\_ Weeks/Days suspended for delinquent charts \_\_\_\_\_

- Provide information on actions taken as a result of peer review activities. These include:

\_\_\_\_\_ Surgery Case Review \_\_\_\_\_ Utilization Review \_\_\_\_\_ Medical Record Review \_\_\_\_\_ Drug Utilization

\_\_\_\_\_ Blood Utilization \_\_\_\_\_ Risk Management \_\_\_\_\_ Case Management Monitoring

Explain if any are checked (attach additional paper as needed):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Facility: \_\_\_\_\_ 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