



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:

| PRIVILEGE | CONDITION/EXCEPTION |
|------------------|----------------------------|
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| | |

7. APPROVALS:

SERVICE CHIEF _____ **DATE** _____

MEC _____ **DATE** _____

BOARD _____ **DATE** _____



**Ville Platte/Eunice
FAMILY NURSE PRACTITIONER**

Name: _____

| REQUESTED | PROCEDURE / DIAGNOSIS | EX/CR COMM. | | B. O. D. | |
|---|--|-------------|-----|----------|--------|
| | | RECC | NOT | APPROVE | DENIED |
| ALLERGY | | | | | |
| | DIFFERENTIAL DIAGNOSIS | | | | |
| | HAY FEVER | | | | |
| | UTICARIA | | | | |
| | ASTHMA, UNCOMPLICATED | | | | |
| CARDIAC DISEASE | | | | | |
| | DIFFERENTIAL DIAGNOSIS | | | | |
| | CARDIAC ARRHYTHMIAS, ON EST. REGIME | | | | |
| | CORONARY ARTERY DISEASE | | | | |
| | CONGESTIVE HEART FAILURE, ON EST. REGIME | | | | |
| COLLEGEN DISEASE | | | | | |
| | DIFFERENTIAL DIAGNOSIS | | | | |
| GASTROINTESTINAL DISEASE | | | | | |
| | DIFFERENTIAL DIAGNOSIS | | | | |
| | PEPTIC ULCER | | | | |
| | ULCERATIVE COLITIS | | | | |
| | GASTROENTERITIS | | | | |
| HEMATOLOGICAL DISEASE | | | | | |
| | DIFFERENTIAL DIAGNOSIS | | | | |
| | PRIMARY ANEMIA | | | | |
| HEPATIC DISEASE | | | | | |
| | DIFFERENTIAL DIAGNOSIS | | | | |
| | HEPATITIS | | | | |
| | JAUNDICE | | | | |
| HYPERTENSION | | | | | |
| | DIFFERENTIAL DIAGNOSIS | | | | |
| | UNRESPONSIVE ESSENTIAL | | | | |
| METABOLIC AND ENDOCRINE DISEASES | | | | | |
| | DIFFERENTIAL DIAGNOSIS | | | | |
| | DIABETES MELLITUS | | | | |
| | THYROID CONDITIONS, SIMPLE HYPO & HYPER | | | | |
| PERIPHERAL VASCULAR DISEASE | | | | | |
| EMOTIONAL / BEHAVIORAL DISORDERS | | | | | |
| | EATING DISORDERS | | | | |
| | ORGANIC BRAIN SYNDROME | | | | |
| | ACUTE SITUATIONAL PROBLEMS | | | | |



FAMILY NURSE PRACTITIONER

Name: _____

| REQUESTED | PROCEDURE / DIAGNOSIS | EX/CR COMM. | | B. O. D. | |
|-------------------------------------|--|-------------|-----|----------|--------|
| | | RECC | NOT | APPROVE | DENIED |
| PULMONARY DISEASE | | | | | |
| | DIFFFERENTIAL DIAGNOSIS | | | | |
| | PNEUMONIA, SIMPLE, VIRAL & BACTERIAL | | | | |
| | EMPHYSEMA | | | | |
| | BRONCHITIS | | | | |
| RENAL DISEASE | | | | | |
| | DIFFFERENTIAL DIAGNOSIS | | | | |
| | PYELONEPHRITIS | | | | |
| | URINARY TRACT INFECTION | | | | |
| NEUROLOGICAL DISEASE | | | | | |
| | DIFFFERENTIAL DIAGNOSIS | | | | |
| | CONVULSIVE STATES, ON MAINT. REGIME | | | | |
| | PARKINSONISM, ON MAINT. REGIME | | | | |
| | SYNCOPE | | | | |
| RHEUMATOLOGY | | | | | |
| | DIFFFERENTIAL DIAGNOSIS | | | | |
| | OSTEOARTHRITIS | | | | |
| PEDIATRICS | | | | | |
| | INTERMEDIATED CARE OF PEDIATRIC PATEINTS WITH UNCOMPLICATED ACUTE DISEASES | | | | |
| OBSTETRICS | | | | | |
| | DIAGNOSIS AND TRIAGE | | | | |
| | ECHO EXAM FOR FETAL GROWTH | | | | |
| | FETAL NON-STRESS TESTING / FETAL BIOPHYSICAL PROFILE | | | | |
| SKIN AND SUBCUTAENOUS TISSUE | | | | | |
| | SUTURE WOUNDS | | | | |
| | INCISION & DRAINAGE | | | | |
| | DEBRIDE SKIN, PARTIAL THICKNESS | | | | |
| | DEBRIDE NAIL | | | | |
| | WEDGE EXCISION, SKIN OF NAIL | | | | |
| | DECUBITUS ULCERS, STAGE I & II | | | | |
| | BURNS, 1ST AND 2ND DEGREE (SMALL AREA) | | | | |
| | SIMPLE REMOVAL FOREIGN BODY | | | | |
| | TISSUE BIOPSY | | | | |



FAMILY NURSE PRACTITIONER

Name: _____

| GYNECOLOGY & UROLOGY | | | | | |
|---|--|--|--|--|--|
| DESTROY VULVA LESIONS(S); SIMPLE | | | | | |
| BIOPSY OF VULVA OR PERINEUM | | | | | |
| EXAMINATION OF VAGINA | | | | | |
| VAGINA BIOPSY | | | | | |
| CRYOCAUTERY OF CERVIX | | | | | |
| ECHO EXAM OF PELVIS | | | | | |
| ECHOGRAPHY, PREGNANT UTERUS, TRANS-VAGINAL, PELVIC | | | | | |
| FITTING & INSERTION OF PESSAARY OT OTHER INTRAVAGINAL SUPPORT DEVICES | | | | | |
| INJECTION PROCEDURE FOR CYSTOGRAPHY OR VOIDING URETHROCYSTOGRAPHY | | | | | |
| BLADDER IRRIGATION, SIMPLE, LAVAGE AND/OR INSTILLATION | | | | | |
| SIMPLE CYSTOMETROGRAM | | | | | |
| COMPLEX CYSTOMETROGRAM | | | | | |
| COMPLE UROFLOWMETRY | | | | | |
| URETHRAL PRESSURE PROFILE STUDIES | | | | | |
| ELECTROMYOGRAPHY STUDIES OF ANAL OR URETHRAL SPHINCTER, OTHER THAN NEEDLE | | | | | |
| VOIDING PRESSURE STUDIES, BLADDER VOIDING PRESSURE | | | | | |
| INTRA-ABDOMINAL VOIDING PRESSURE | | | | | |
| ADDITIONAL PRIVILEGES | | | | | |
| RHYTHM STRIP INTERPRETATION | | | | | |
| ARTHROCENTESIS, MAJOR JOINT | | | | | |
| INSERTION OF ORAL PHARYNGEAL AIRWAY | | | | | |
| INSERTION OF ESOPHAGEAL OBTURATOR AIRWAY | | | | | |
| ENDOTRACHEAL INTUBATION | | | | | |
| SPLINTING OF FRACTURES AND DISLOCATIONS | | | | | |
| DISLOCATION REDUCTION TECHNIQUES | | | | | |
| ACLS | | | | | |
| CPR | | | | | |



FAMILY NURSE PRACTITIONER

Name: _____

| ADDITIONAL PRIVILEGES, CONTINUED | | | | | |
|----------------------------------|---|--|--|--|--|
| | INITIAL INTERPRETATION OF X-RAYS (MUST BE OVERREAD BY PHYSICIAN) | | | | |
| | URINALYSIS AND MICROSCOPY | | | | |
| | INHALATION THERAPY PER NEBULIZER | | | | |
| | INITIAL INTERPRETATION EKG'S | | | | |
| | ORDERING AND INTERPRETATION OUTPATIENT LAB & X-RAY (MUST HAVE PRESCRIPTIVE AUTHORITY) | | | | |
| | PRESCRIPTIVE/MEDICATION MANAGEMENT (MUST HAVE PRESCRIPTIVE AUTHORITY) | | | | |
| | CONTROLLED SUBSTANCE ORDERING & MANAGEMENT (MUST HAVE DEA#) | | | | |
| | PHYSICAL ASSESSMENT & EXAMINATIONS | | | | |
| | REFERRALS TO AGENCIES & PROVIDERS | | | | |
| | EDUCATION & PATIENT TEACHING | | | | |
| | DICTION OF H&P | | | | |
| | DICTION OF DISCHARGE SUMMARY | | | | |
| | TREATMENT OF COLLAPSED LUNG | | | | |
| | LARYNGOSCOPY FOR ASPIRATION | | | | |
| | CONSULTATION | | | | |
| | CONSULTATIVE FOLLOW-UP | | | | |
| | CONFIRMATORY CONSULTATION | | | | |
| | THERAPEUTIC INJECTION OF MEDICATION | | | | |
| | DIAGNOSTIC INTERVIEW | | | | |

I hereby apply for privileges as defined above.

Date

Signature of Applicant

I hereby verify that the applicant has the knowledge & competency to include above requested privileges in his/her scope of practice.

Date

Signature of Collaborating Physician



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:

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