



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

7. APPROVALS:

SERVICE CHIEF _____ **DATE** _____

MEC _____ **DATE** _____

BOARD _____ **DATE** _____



**Ville Platte—Eunice
Family Practice
Core Privileges**

Criteria for Appointment:

Basic Education: MD or DO

Minimal formal training: Successful completion of an AAFP (American Academy of Family Physicians)/AOBFP (American Osteopathic Board of Family Practice) residency training program in Family Practice.

Required previous experience: The successful applicant must be able to demonstrate provision of inpatient services to at least 30 patients in the past 12 months. OR A letter of reference from the residency director or the chief of medicine from another hospital where the applicant has been affiliated for the last two years.

Core Privileges-Family Practice *Requested* _____ *Granted* _____

Privileges include admission, evaluation, diagnosis, and treatment, including consult for patients, pediatric and adult, admitted or in need of care to treat general medical problems. Includes Category I privileges for uncomplicated, basic procedures and cognitive skills.

Category II-Includes core privileges and privileges for those procedures and cognitive skills involving more serious medical problems which normally are acquired during successful completion of a family practice residency program.

Category III- Requires special skills and knowledge and, therefore, documentation of such training and experience which may have been acquired in a family practice residency, in a post residency fellowship program, in a special course, or by practice experience.

Category II

• **Alimentary System**

• **Procedural**

- **Biopsy: simple oral lesion**
- **Colonscopy**
 - **With biospy**
 - **With polypectomy**
- **Esophagogastroduodenoscopy**

<u>Requested</u>	<u>Granted</u>
_____	_____
_____	_____
_____	_____
_____	_____

- With biopsy
 - Hemorrhoidectomy: banding or infrared
 - Hyperalimentation
 - Liver biopsy: fine needle
 - Paracentesis: abdominal
 - Polypectomy: rectal
 - Proctosigmoidoscopy
 - Flexible with biopsy
- **Cardiovascular System**
 - **Procedural**
 - Arterial line placement
 - Cardioversion: medical
 - Central venous placement and monitoring
 - EKG interpretation
 - Myocardial infarction: complicated
 - Stress testing: exercise treadmill
 - Thoracentesis: needle/catheter
 - Venous cutdown and cannulation
- **Ear Nose and Throat**
 - **Procedural**
 - Abscess of auricle: drainage
 - Cricothyroidotomy
 - Epistaxis: anterior/posterior pack
 - Endotracheal: intubation
 - Foreign body: ear, nose throat
 - Frenulum release lingual or labial
 - Oral lesions: biopsy and excision: simple
- **Endometabolic Systems**
 - **Procedural**
 - Fine needle biopsy: superficial lymph node or thyroid
- **Eye**
 - **Procedural**
 - Slit lamp exam
 - Tumors of lid or orbit: biopsy
- **Genital System: Female**
 - **Procedural**
 - Biopsy: vulva and vagina
 - Cervix: cryosurgery
 - Culdocentesis
 - Endometrial bx/aspiratin currettage
 - Sub-cutaneous contraceptive device:
 - Insertion/removal
 - Veneral warts: treatment
 - Vulvar abscess: treatment
- **Genital System: Male**

	<u>Requested</u>	<u>Granted</u>
• <u>Procedural</u>		
• Vasectomy	_____	_____
• <u>Hematologic System</u>		
• <u>Procedural</u>		
• Bone marrow aspiration	_____	_____
• Bone marrow biopsy	_____	_____
• Lymph node: superficial biopsy or excision	_____	_____
• <u>Musculoskeletal System</u>		
• <u>Procedural</u>		
• Extensor tendon repair: simple/primary	_____	_____
• Fracture care: closed reduction	_____	_____
• Incision and drainage of the abscess	_____	_____
• <u>Procedural</u>		
• Nasogastric intubation	_____	_____
• Proctosigmoidoscopy	_____	_____
• EKG Interpretation	_____	_____
• Internal jugular venipuncture	_____	_____
• Intravenous therapy: neonate	_____	_____
• Intravenous therapy: infant	_____	_____
• Intravenous therapy: Child	_____	_____
• Venipuncture including scalp vein	_____	_____
• Venous cutdown	_____	_____
• Suprapubic bladder tap	_____	_____
• Musculoskeletal:		
• Arthrocentesis	_____	_____
• Fracture care: simple	_____	_____
• Preterm: uncomplicated	_____	_____
• Full term: complicated	_____	_____
• Attend infant at cesarean section	_____	_____
• Neonatal resuscitation	_____	_____
• Umbilical artery or vein catheterization	_____	_____
• Nervous System		
• Lumbar Puncture	_____	_____
• Surgical Assist		
• Casarean section	_____	_____
• Infant	_____	_____
• Child	_____	_____
• <u>Pregnancy, Childbirth, and Puerperium</u>		
• <u>Procedural</u>		
• Cervical laceration repair	_____	_____
• Delivery:		
• Uncomplicated, normal cephalic; term	_____	_____
• With outlet forceps	_____	_____
• Uncomplicated, normal cephalic; preterm	_____	_____
	<u>Requested</u>	<u>Granted</u>

- Ectopic pregnancy: medical management _____
- Surgical Management _____
 - Episiotomy repair: 1st and 2nd degree _____
 - Episiotomy repair: 3rd and 4th degree _____
 - Fetal monitoring _____
 - Fetal scalp pH _____
 - Induction of labor _____
 - Labor: augmentation _____
 - Placenta: manual removal _____
 - Paracervical block _____
 - Pudendal block _____
 - Vacuum delivery _____
- Sports and Recreational Medicine _____
 - Procedural _____
 - Casting, splinting and bracing _____

Category III

- Alimentary System _____
 - Procedural _____
 - Appendectomy _____
 - Colonoscopy _____
 - Esophagus: dilation of _____
 - Esophagogastroduodenoscopy _____
 - With PEG placement _____
 - Hemorrhoidectomy: surgical _____
 - Peritonsillar abscess drainage _____
 - Cardiovascular System _____
 - Procedural _____
 - Cardioversion: electrical _____
 - Pacemaker: venous/temporary _____
 - Pacemaker: venous/permanent _____
 - Pericardiocentesis _____
 - Stress testing: chemical/nuclear _____
 - Swan Ganz placement and monitoring _____
 - Temporal artery biopsy _____
 - Ear Nose and Throat _____
 - Procedural _____
 - Endoscopy: with foreign body removal _____
 - Laryngoscopy: direct _____
 - Myringotomy and aspiration _____
 - Rhinolaryngoscopy: fibertopic _____
- Requested* *Granted*
- Tracheostomy: elective or emergency _____
 - Eye _____

• <u>Procedural</u>		
• Tumors of lid or orbit: excision	_____	_____
• <u>Genital System: Female</u>		
• <u>Procedural</u>		
• Bartholin's cyst: drainage or marsupialization	_____	_____
• Cervix: biopsy and polypectomy	_____	_____
• Colposcopy and biopsy	_____	_____
• Conization of cervix	_____	_____
• Dilation and curettage	_____	_____
• Hymenotomy	_____	_____
• Hysterosalpingogram	_____	_____
• Hysteroscopy	_____	_____
• IUD: insertion/removal	_____	_____
• LEEP	_____	_____
• Sub-cutaneous contraceptive device:	_____	_____
• Laparoscopic	_____	_____
• Open	_____	_____
• <u>Genital System: Male</u>		
• <u>Procedural</u>		
• Androscopy	_____	_____
• Circumcision: non-infant	_____	_____
• Epididymitis: aspiration of speratocele	_____	_____
• Meatotomy	_____	_____
• Testis: needle biopsy	_____	_____
• Tunica vaginalis: needle aspiration of hydrocele	_____	_____
• Varicocelectomy	_____	_____
• <u>Immune System</u>		
• <u>Procedural</u>		
• Dermal skin testing	_____	_____
• <u>Musculoskeletal System</u>		
• <u>Procedural</u>		
• Carpel tunnel release	_____	_____
• Ganglionectomy	_____	_____
• Ganglion: aspiration/drainage	_____	_____
• Hip dislocation: reduction	_____	_____
• Muscle biopsy	_____	_____
• Nail matrix destruction	_____	_____
• Nail plate removal	_____	_____
• <u>Renal System</u>		
• <u>Procedural</u>		
	<u>Requested</u>	<u>Granted</u>
• Circumcision: adult	_____	_____
• Cystourethroscopy	_____	_____
• <u>Respiratory System</u>		
• <u>Procedural</u>		

- | | | |
|---|-------------------------|-----------------------|
| • Biopsy of lung: needle | _____ | _____ |
| • Biopsy of pleura: needle | _____ | _____ |
| • Bronchoscopy: flexible | _____ | _____ |
| • Bronchoscopy: rigid | _____ | _____ |
| • Tube thoracostomy (chest tube) | _____ | _____ |
| • <u>Skin, Appendages, Subcutaneous tissues</u> | | |
| • <u>Procedural</u> | | |
| • Breast: open biopsy | _____ | _____ |
| • Varicose vein surgery | _____ | _____ |
| • <u>Special Problems and Special Populations: Child</u> | | |
| • <u>Procedural</u> | | |
| • EGD | _____ | _____ |
| • Paracentesis: abdomen | _____ | _____ |
| • Exchange transfusion | _____ | _____ |
| • <u>Neonatal Care</u> | | |
| • Preterm: complicated | _____ | _____ |
| • Exchange transfusion | _____ | _____ |
| • <u>Nervous System</u> | | |
| • Subdural tap | _____ | _____ |
| • <u>Respiratory</u> | | |
| • Chest tube placement | _____ | _____ |
| • Thoracentesis | _____ | _____ |
| • Tympanocentesis | _____ | _____ |
| • <u>Pregnancy, Childbirth, and Puerperium</u> | | |
| • <u>Procedural</u> | | |
| • Amniocentesis | _____ | _____ |
| • Cesarean section | _____ | _____ |
| • Delivery: | | |
| • Complicated: breech | _____ | _____ |
| • Complicated; abnormal/compound presentation | _____ | _____ |
| • Multiple delivery | _____ | _____ |
| • Dilation and curettage | _____ | _____ |
| • Surgical Management | | |
| • Intrauterine demise; management | _____ | _____ |
| • Labor: inhibition of | _____ | _____ |
| • Placenta: abruption | _____ | _____ |
| • Placenta: previa | _____ | _____ |
| | <u>Requested</u> | <u>Granted</u> |
| • Pre-eclampsia or eclampsia: management | _____ | _____ |
| • Regional anesthesia: epidural, spinal or saddle block | _____ | _____ |
| • Ultrasound assessment | _____ | _____ |
| • Vacuum curettage: incomplete abortion | _____ | _____ |

Applicant Signature

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:

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