



**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**

**PRIVILEGES IN GENERAL AND VASCULAR SURGERY**

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

**GENERAL AND VASCULAR SURGERY CORE PRIVILEGES**

**QUALIFICATIONS**

To be eligible for core privileges in general surgery, the applicant must meet the following qualifications:

- Documentation of the performance of at least 100 general surgical procedures during the last two years, or demonstrated successful completion of a hospital-affiliated formalized residency or clinical fellowship;
- Current certification or active participation in the examination process leading to certification in general or vascular surgery by the American Board of Surgery or the American Osteopathic Board of Surgery; or
- (Applicable to physicians seeking initial appointment subsequent to the Board’s Policy on appointment, reappointment and clinical privileges, dated May 24, 2001). Successful completion of postgraduate residency in general surgery accredited by the ACGME, AOA, or equivalent.

**Privileges included in the general surgery core:**

Privileges to admit, evaluate, diagnose, consult, provide pre-, intra-, and postoperative surgical care; and perform surgical procedures for patients of all ages—except where specifically excluded from practice and except for those special procedures privileges listed below—to correct or treat various conditions, illnesses, and injuries of the alimentary tract, abdomen and its contents, breast, skin, soft tissue, head and neck, endocrine system, and minor extremity surgery. Privileges include, but are not limited to, insertion and management of arterial catheter, insertion and management of chest tubes, insertion and management of central venous catheters; lumbar puncture; pericardiocentesis; tracheostomy; paracentesis; and management of trauma and complete care of critically ill patients with underlying surgical conditions in the emergency department, intensive care unit, and trauma/burn units.

<input type="checkbox"/> Requested	<input type="checkbox"/> Recommended	<input type="checkbox"/> Not Recommended
<input type="checkbox"/> Recommended with the following modifications(s) and reason(s).		

**Qualifications**

To be eligible for core privileges in vascular surgery, the applicant must meet the following qualifications:

- Documentation of the performance of at least 100 vascular surgical procedures during the last two years, or demonstrated successful completion of a hospital-affiliated formalized residency or clinical fellowship;
- Current certification or active participation in the examination process leading to certification in general or vascular surgery by the American Board of Surgery or the American Osteopathic Board of Surgery; or
- (Applicable to physicians seeking initial appointment subsequent to the Board’s Policy on appointment, reappointment and clinical privileges, dated May 24, 2001). Successful completion of an ACGME- OR AOA-accredited five-year residency program to include four years of general surgery plus one year of vascular training.

**Privileges included in the vascular surgery core**

Privileges to admit, evaluate, diagnose, provide pre-, intra-, and postoperative surgical care and perform surgical procedures for patients of all ages—except where specifically excluded from practice and except for those special procedures listed below—to correct or treat diseases and disorders of the arterial, venous, and lymphatic circulatory systems, excluding those of the heart, thoracic aorta, and intracranial contents.

<input type="checkbox"/> <b>Requested</b>	<input type="checkbox"/> <b>Recommended</b>	<input type="checkbox"/> <b>Not Recommended</b>
<input type="checkbox"/> <b>Recommended with the following modifications(s) and reason(s).</b>		

**Special Procedures Privileges**

To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship or other acceptable experience; and provide documentation of competence in performing that procedure to the satisfaction of the credential’s committee and the Board of Trustees.

Procedure	Requested	Recommended	Not Recommended
Interpretation of vascular imaging studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advanced laparoscopic surgery (excluding laparoscopic cholecystectomy and laparoscopic appendectomy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insertion and management of peritoneal hemodialysis catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stereotactic breast biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sentinel node biopsy for cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of conscious sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Recommended/Not Recommended with the following modification(s) and reason(s):**

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**Acknowledgment of Practitioner**

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Logan General Hospital, and;

I understand that

- (a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
- (b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

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Name

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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