



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:

PRIVILEGE	CONDITION/EXCEPTION

7. APPROVALS:

SERVICE CHIEF _____ **DATE** _____

MEC _____ **DATE** _____

BOARD _____ **DATE** _____



Ville Platte/Eunice

Pathology Core Privileges

Criteria for Appointment:

Basic Education: MD or DO

Minimal formal training: Successful completion of an ACGME/AOA-accredited training program in clinical and/or anatomical pathology.

Required previous experience: The successful applicant must be able to demonstrate that he or she has provided full-time, in-hospital pathology/laboratory services for at least 12 of the past 18 months. Recent residency training satisfies this requirement.

Core Privileges-Pathology *Requested* _____ *Granted* _____

Privileges in anatomical and clinical pathology include provision of consultation to physicians for diagnosis, exclusion, and monitoring of disease utilizing information gathered from microscopic examination of tissue specimens, cells, and body fluids and from clinical laboratory tests on body fluids and secretions.

Special Privileges-Pathology

- | | | |
|--------------------------------------|------------------------|----------------------|
| • Blood banking/transfusion medicine | <i>Requested</i> _____ | <i>Granted</i> _____ |
| • Chemical pathology | <i>Requested</i> _____ | <i>Granted</i> _____ |
| • Cytopathology | <i>Requested</i> _____ | <i>Granted</i> _____ |
| • Forensic pathology | <i>Requested</i> _____ | <i>Granted</i> _____ |
| • Hematology | <i>Requested</i> _____ | <i>Granted</i> _____ |
| • Medical microbiology | <i>Requested</i> _____ | <i>Granted</i> _____ |
| • Neuropathology | <i>Requested</i> _____ | <i>Granted</i> _____ |
| • Pediatric pathology | <i>Requested</i> _____ | <i>Granted</i> _____ |
| • Dermatopathology | <i>Requested</i> _____ | <i>Granted</i> _____ |

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



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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: _____



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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