



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
PHYSICIAN ASSISTANT

NAME: _____

SPONSORING PHYSICIAN:

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					
	ORGANIC BRAIN SYNDROME				
	ACUTE SITUATIONAL PROBLEMS				
	EATING DISORDERS				



PHYSICIAN ASSISTANT

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				
SKIN AND SUBCUTAENOUS TISSUE					
	SUTURE WOUNDS				
	INCISION & DRAINAGE				
	DECUBITUS ULCERS, STAGE I & II				
	BURNS, 1ST AND 2ND DEGREE				
	TISSUE BIOPSY				
ADDITIONAL PRIVILEGES					
	RHYTHM STRIP INTERPRETATION				
	INSERTION OF ORAL PHARYNGEAL AIRWAY				
	INSERTION OF ESOPHAGEAL OBTURATOR AIRWAY				
	ENDOTRACHEAL INTUBATION				
	SPLINTING OF FRACTURES AND DISLOCATIONS				
	DISLOCATION REDUCTION TECHNIQUES				
	ACLS				
	CPR				



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