



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:

<b>PRIVILEGE</b>	<b>CONDITION/EXCEPTION</b>

**7. APPROVALS:**

**SERVICE CHIEF** \_\_\_\_\_ **DATE** \_\_\_\_\_

**MEC** \_\_\_\_\_ **DATE** \_\_\_\_\_

**BOARD** \_\_\_\_\_ **DATE** \_\_\_\_\_



**Ville Platte/Eunice  
Privileges in Podiatry**

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

**Podiatry Core Privileges**

**Qualifications**

To be eligible for core privileges in podiatry, the applicant must meet the following qualifications

- Documentation of the performance of at least 50 podiatric surgical procedures in the past two years; **and**
- Demonstrated successful completion of a one-year surgical residency, or a one-year postgraduate training program in podiatric orthopedics, or a one-year postgraduate training program in primary podiatric medicine. Both the surgical residency and the postgraduate training programs must be approved by the CPME.
- Podiatrists without such training must demonstrate current competence by documented proof of training and experience.
- **Privileges to complete admission history and physical examination on patients without significant medical problems (patients in Class 1 and 2 of the American Society of Anesthesiologist (ASA) Classification System<sup>1</sup>). Patients in ASA Class 3, 4, or 5 will require a M.D. or D.O. evaluation upon admission or scheduling of outpatient procedures.**

**<sup>1</sup>American Society of Anesthesiologist (ASA) Classification System**

- 1 The patient is normal and healthy.
  - 2 The patient has mild systemic disease that does not limit their activities (e.g., controlled hypertension or controlled diabetes without systemic sequellae.
  - 3 The patient has moderate or severe systemic disease, which does limit their activities (e.g., stable angina or diabetes with systemic sequellae.
  - 4 The patient has severe systemic disease that is a constant potential threat to life (e.g. severe congestive heart failure, end stage renal failure).
  - 5 The patient is morbid and is at substantial risk of death within 24 hours, with or without intervention.
- E Emergency status: In addition to indicating underlying ASA status (1-5), any patient undergoing an emergency procedure is indicated by the suffix "E". For example, a fundamentally healthy patient undergoing an emergency procedure is classified as 1-E. If the patient is undergoing an elective procedure, the "E" designation is not used.

**CLASS A: PODIATRIC PROCEDURES:**

Qualifications

- Documentation of the performance of at least 50 digital, forefoot and simple rearfoot procedures in the past two years.
- Either Board Qualified or Board Certified in Foot Surgery by the American Board of Podiatric surgery

Admit, evaluate, diagnose, provide consultation, order diagnostic studies and perform surgical or non-surgical podiatric procedures on the toes and forefoot and procedures on patients of all ages—except as specifically excluded from practice and except for those special procedure privileges listed below- presenting with injuries or diseases of the foot.

\*Excluded:

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

**CLASS B: PODIATRIC PROCEDURES:**

Qualifications

- All of the qualifications for Class A podiatric procedures, plus documentation of the performance of at least 30 rearfoot and ankle procedures in the past two years
- Demonstrated successful completion of a three-year surgical residency.
- Either Board Qualified or Board Certified in reconstructive rearfoot/ankle surgery by the ABPS

**Privileges included in the class B podiatric core:**

Privileges include those in Class A plus performance of complex rearfoot and ankle surgical procedures, except for those special procedures privileges listed below.

\*Excluded:

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

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 consistent with the criteria set forth in the medical staff policies governing the exercise of specific

	<b>Criteria</b>	<b>Requested</b>	<b>Recommended</b>	<b>Not Recommended</b>
Midas Rex	Course Completion			
Laser	Course Completion			
Ankle Arthroscopy	Course Completion or Documented Experience			
Ankle Arthroplasty	Course Completion			

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

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### **Acknowledgement 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 **Acadian Medical Center**, 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.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

### **Department Chair's Recommendations**

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Signed: \_\_\_\_\_

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