



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
SURGICAL ASSIST (RN, LPN, ORT)**

NAME:

	REQUESTED
<i>Under the Direct Supervision of Dr. ,applicant will be allowed to:</i>	
Participate in the safe positioning of the surgical patient	
Assist in maintaining visualization of the operative site during the operative procedure	
Demonstrate the proper techniques to assist the surgeon in obtaining instruments, resources and retraction during the procedure.	
Demonstrate the appropriate techniques to assist with retraction of body tissue	
Participate in expediting the operative procedure by anticipating the needs of the surgeon.	
Demonstrate knowledge of normal anatomy	
Participate in responding to emergency situations	
Demonstrate organizational skills	
Demonstrate professional attitude	

I hereby request approval to perform the above duties.

Signature of Applicant

Date

I hereby verify that the applicant is competent to perform the above duties under my direct supervision.

Signature of Sponsoring Physician

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

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