

**REHOBOTH MCKINLEY CHRISTIAN HOSPITAL (RMCH)  
REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES (RMCHCS)  
CLINICAL PRIVILEGES APPLICATION**

**PHYSICIAN ASSISTANT**

APPLICANT NAME: \_\_\_\_\_

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**CORE INPATIENT AND OUTPATIENT PRIVILEGES:**

Physician assistant privileges include at least the following duties:

1. Initial and ongoing assessment of patients' medical, physical, and psychological status, including:
  - Conduct histories
  - Develop treatment plans
  - Perform rounds
  - Record progress notes
2. Implement physician-directed treatment plan, including:
  - Write orders for medications, treatments, tests, IV fluids (counter-signed by supervising physician)
  - Provide pre-and postoperative surgical care
3. Patient education and counseling covering health status, test results, disease process, and discharge planning.

**The core privileges do not include any privilege listed under Special Privileges.**

**NOTE: In the case of an emergency, to the degree permitted by license and regardless of department, staff status or clinical privileges, shall be permitted and shall be assisted by hospital personnel to do everything possible to save a patient from serious harm.**

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**QUALIFICATIONS FOR CORE PRIVILEGES:**

\_\_\_ Graduate of a Commission on Accreditation of Allied Health Education Programs (CAAHEP) and certified by the National Commission of Certification of Physician Assistants.

Other training, please explain:

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**EXPLANATION FOR REQUESTING PRIVILEGES:**

**RMCHCS is an integrated health care delivery system which operates both a hospital that provides inpatient care and some outpatient services, RMCH, and clinics or other outpatient facilities such as dialysis centers, home health services, hospice services, day care services, etc. Employed practitioners of RMCHCS may need to apply for privileges in either inpatient or outpatient setting, or both. Non-RMCHCS employed physicians may need to apply for privileges at the hospital only. Therefore, RMCHCS uses a single application that will allow practitioners to request privileges for hospital (RMCH on the application) and/or outpatient care (RMCHCS on the application) as appropriate. On the following page(s) appear the privileges appropriate for your specialty and location(s) of practice. If a privilege is desired that is not listed, please list it in the space designated. For all special privileges, an applicant is required to identify education and/or experience before privilege(s) will be evaluated.**

PHYSICIAN ASSISTANT PRIVILEGES APPLICATION

NAME: \_\_\_\_\_

**CORE PRIVILEGES**

REQUESTED

INPATIENT/OUTPATIENT

Yes No / Yes No

\_\_\_ \_\_\_/\_\_\_ \_\_\_

Core physician assistant privileges (see page 1)

RECOMMENDED

INPATIENT/OUTPATIENT

Yes No / Yes No

\_\_\_ \_\_\_/\_\_\_ \_\_\_

**SPECIAL PRIVILEGES:** For each special request, you must state the training and number of procedures during training; or number of procedures performed in the last 12 months. If any one or all special privileges are not needed, YOU MUST CHECK "NO" UNDER "PRIVILEGES REQUESTED".

Yes No / Yes No

\_\_\_ \_\_\_ NA NA

Assist at general surgery

Training/Experience: \_\_\_\_\_

Yes No / Yes No

\_\_\_ \_\_\_/NA NA

Yes No / Yes No

\_\_\_ \_\_\_ NA NA

Assist at orthopedic surgery

Training/Experience: \_\_\_\_\_

Yes No / Yes No

\_\_\_ \_\_\_/NA NA

Yes No / Yes No

\_\_\_ \_\_\_ NA NA

Assist at OB/GYN surgery

Training/Experience: \_\_\_\_\_

Yes No / Yes No

\_\_\_ \_\_\_/NA NA

Yes No / Yes No

\_\_\_ \_\_\_ \_\_\_ \_\_\_

Applying and removing orthopedic casts/traction

Training/Experience: \_\_\_\_\_

Yes No / Yes No

\_\_\_ \_\_\_/\_\_\_ \_\_\_

Yes No / Yes No

\_\_\_ \_\_\_ \_\_\_ \_\_\_

Cleansing and debriding wounds

Training/Experience: \_\_\_\_\_

Yes No / Yes No

\_\_\_ \_\_\_/\_\_\_ \_\_\_

Yes No / Yes No

\_\_\_ \_\_\_ NA NA

Endotracheal intubation

Training/Experience: \_\_\_\_\_

Yes No / Yes No

\_\_\_ \_\_\_/NA NA

Yes No / Yes No

\_\_\_ \_\_\_ \_\_\_ \_\_\_

Inserting indwelling urinary catheters

Training/Experience: \_\_\_\_\_

Yes No / Yes No

\_\_\_ \_\_\_/\_\_\_ \_\_\_

Yes No / Yes No

\_\_\_ \_\_\_ NA NA

Nasogastric intubation

Training/Experience: \_\_\_\_\_

Yes No / Yes No

\_\_\_ \_\_\_/NA NA

**ADDITIONAL PRIVILEGES (Specify inpatient and/or outpatient, stated with training/experience):**

\_\_\_\_\_  
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PHYSICIAN ASSISTANT PRIVILEGES APPLICATION

NAME: \_\_\_\_\_

**I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Rehoboth McKinley Christian 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 situation my actions are governed by the applicable section of the medical staff bylaws or related documents

APPLICANT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

NOTE: Physician assistants must identify a supervising or directing physician(s). The primary supervising physician will attest by signature to the competency of the privileges requested.

**NAME OF PHYSICIAN (S):**  
\_\_\_\_\_

**SIGNATURE OF PRIMARY PHYSICIAN:**  
\_\_\_\_\_

**DATE:** \_\_\_\_\_

DEPARTMENT REVIEW:  
Comments/Recommendations/Suggestions:  
\_\_\_\_\_  
\_\_\_\_\_  
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Signed: \_\_\_\_\_  
 Medical Staff Department Chairperson  
 \_\_\_\_\_  
 Date of Review  
 \_\_\_\_\_  
 Medical Staff Department

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