



LANE REGIONAL MEDICAL CENTER  
PRIVILEGES APPLICATION FORM  
INTERNAL MEDICINE

R G A

- Admit, evaluate, diagnose, manage, and
- Core Privileges
- Advanced cardiac life support
- Abdominal paracentesis
- Arterial puncture
- Arthrocentesis
- Central venous line placement
- Lumbar puncture
- Nasogastric intubation
- Pap smear and endocervical culture
- Thoracentesis
- Electrocardiograms Interpreting
- ECHO Cardigram Interpretation
- Holter Monitoring and Interpretation
- Pulmonary Function Interpretation
- Treadmill Exercise Testing
- Pacemaker-Temporary
- Pacemaker-Permanent
- Insertion and Management
- EGD (Esophagoscopy, Gastroscopy, Duodenoscopy)
- Colonoscopy
- Indirect Laryngoscopy

- Flexible Sigmoidoscopy
- Intro-luminary Anti-reflex procedures
- PH Study with Bravo capsule
- Esophageal Motility Studies
- Ventilator Management
- Bone Marrow Aspiration
- Bone Marrow Biopsy
- Administration of Conscious Sedation
- Bronchoscopy
- Closed Pleural Biopsy

Applicant signature \_\_\_\_\_ Date \_\_\_\_\_



## Lane Regional Medical Center Internal Medicine Privileges

Print Name: \_\_\_\_\_

**To be eligible to apply for core privileges in Internal Medicine, the applicant must meet the following qualifications:**

- Education:** M.D. or D.O. degree
- Training:** Documented successful completion of an ACGME/AOA accredited residency training program in Internal Medicine.
- Licensure:** Have a current, active license to practice medicine in the State of Louisiana.
- Experience:** Documentation of provision of inpatient care to at least thirty (30) patients in the past twelve (12) months or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.
- Reappointment:** Satisfactory Performance Improvement findings at Lane Regional Medical Center or primary hospital of practice.

**GENERAL INTERNAL MEDICINE CORE PRIVILEGES – Cross out individual privileges below that are not currently performed in your practice and which you do not request.**

Requested    Approved

\_\_\_\_\_    \_\_\_\_\_    Admit, evaluate, diagnose, manage, and provide non-surgical treatment or consultative services to patients above the age of 12 admitted with both common and complex illnesses.

Core Privileges includes performing the following procedures; understanding their indications, limitations, contraindications; and complications; and interpreting their results: **(mark through those not applicable to your practice)**

- Advanced cardiac life support
- Abdominal paracentesis
- Arterial puncture
- Arthrocentesis
- Central venous line placement
- Lumbar puncture

Nasogastric intubation  
Pap smear and endocervical culture  
Thoracentesis  
Electrocardiograms Interpreting

**CORE PRIVILEGES DOES NOT INCLUDE THE FOLLOWING SPECIAL PROCEDURES:**

**SPECIAL PROCEDURES/TECHNIQUES :**

**To be eligible to apply for a special procedure listed below, the applicant must demonstrate successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship or other acceptable experience, and provide documentation of competence in performing that procedure.**

Requested	Approved	
_____	_____	ECHO Cardigram Interpretation
_____	_____	Holter Monitoring and Interpretation
_____	_____	Pulmonary Function Interpretation
_____	_____	Treadmill Exercise Testing (supervision and interpretation)
_____	_____	Pacemaker – Temporary
_____	_____	Pacemaker – Permanent
_____	_____	Insertion and Management of Right Heart Catheters
_____	_____	EGD (Esophagoscopy, Gastroscopy, Duodenoscopy)
_____	_____	Colonoscopy
_____	_____	Indirect Laryngoscopy
_____	_____	Flexible Sigmoidoscopy
_____	_____	Intro-luminary Anti-reflex procedures
_____	_____	PH Study with Bravo capsule
_____	_____	Esophageal Motility Studies
_____	_____	Ventilator Management
_____	_____	Bone Marrow Aspiration
_____	_____	Bone Marrow Biopsy
_____	_____	Administration of Conscious Sedation
_____	_____	Bronchoscopy
_____	_____	Closed Pleural Biopsy

**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 for which I wish to exercise at Lane Regional Medical Center, and I understand that in exercising any clinical privileges granted, I am constrained by hospital policies and the medical staff bylaws, rules and regulations.

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

**Credentials Committee Recommendation**

We have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

- í Recommend all requested privileges
- í Do not recommend the following requested privileges:
  1. \_\_\_\_\_
  2. \_\_\_\_\_

Chair Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## STATEMENT OF CONFIDENTIALITY

It is the policy of Lane Regional Medical Center and the Medical Staff that any and all information concerning a patient of the facility is of a strictly confidential nature. THIS APPLIES TO VERBAL, WRITTEN OR FAX TRANSMISSIONS. Confidentiality is a right entitled to each patient beginning at admission or upon making a reservation for admission and the right is never terminated. It is the duty and responsibility of every physician, employee and volunteer of Lane Regional Medical Center to ensure that right, both at work and off duty.

By signing below, I signify that I understand and agree to the following:

1. I acknowledge that all information in the patient record (a medical/legal document) including evidence of patient identity as well as the course of clinical treatment is strictly confidential. I will abide by the policy of Lane Regional Medical Center and I will not jeopardize the patient's right to confidentiality (either verbally, in writing or via Fax transmission) of any information which may be used to identify a patient.
2. I agree that in reviewing records, data or hospital documents containing patient information that this information will be used only for the treatment of the patient.
3. I further understand that I could be subject to legal action for violation of any confidences related to patient information.

Name \_\_\_\_\_  
(Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

PHYSICIAN  
STATEMENT OF ACKNOWLEDGMENT

This is to verify that I have received a copy of the following notice to physicians:

**NOTICE TO PHYSICIANS:** Medicare/Champus payments to hospital 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 may be subject to fine, imprisonment, or civil penalty under applicable Federal law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_, M.D.  
Printed Name