



Lane Regional  
Medical Center

1000 NE Oregon Street, Medford, OR 97504

LANE REGIONAL MEDICAL CENTER  
PRIVILEGES APPLICATION FORM  
Physician Assistant

R G A

- Access to Medical Records:
- Dictate/Write H&P - MUST BE COUNTERSIGNED BY PHYSICIAN WITHIN 24 HOURS
- Dictate/Write Progress Note MUST BE COUNTERSIGNED BY PHYSICIAN WITHIN 24 HOURS
- Dictate Discharge Summaries MUST BE COUNTERSIGNED BY PHYSICIAN WITHIN 24 HOURS
- Medical History and Physical (May not serve as a substitute for physician's H&P)
- Interview patient for medical history
- Perform general screening physical exam
- Perform physical exam and evaluations
- Cardiovascular
- Skeletal
- ENT
- Eye
- Gastrointestinal
- Genitourinary
- Neurological
- Obstetrical and Gynecology
- Pediatrics
- Respiratory
- Medical Orders/Protocols:
- Initiate established protocols & transcribe standing orders SIGNED BY PHYSICIAN 24 HRS

\_\_\_ \_\_\_ \_\_\_ Order test & special procedures UNDER DIRECTION OF PHYSICIAN - LISTED BELOW

\_\_\_ \_\_\_ \_\_\_ Any and all blood studies used in the course of general Orthopaedic practice

LANE REGIONAL MEDICAL CENTER  
PRIVILEGES APPLICATION FORM  
Physician Assistant

\_\_\_ \_\_\_ \_\_\_ Diagnostic studies such as EKG, ultrasound etc, used in general Orthopaedic practice

\_\_\_ \_\_\_ \_\_\_ Ordering X-rays, other Imaging studies in general Orthopaedic practice

\_\_\_ \_\_\_ \_\_\_ Ordering PT, OT, etc., typically used in patient care in general Orthopaedic practice

\_\_\_ \_\_\_ \_\_\_ Rounds on patients - not to substitute for physician's daily rounds

\_\_\_ \_\_\_ \_\_\_ Routine Therapeutic Duties:

\_\_\_ \_\_\_ \_\_\_ Administer injections (subcutaneous, intramuscular intravenous)

\_\_\_ \_\_\_ \_\_\_ Administer injections (subcutaneous, intramuscular)

\_\_\_ \_\_\_ \_\_\_ Cleanse and dress wounds

\_\_\_ \_\_\_ \_\_\_ Suture minor wounds and lacerations (after evaluation by supervising physician)

\_\_\_ \_\_\_ \_\_\_ Remove sutures/staples

\_\_\_ \_\_\_ \_\_\_ Insert and change Foley catheters

\_\_\_ \_\_\_ \_\_\_ Insert nasogastric tubes

\_\_\_ \_\_\_ \_\_\_ Administer IV fluids (under physician's order)

\_\_\_ \_\_\_ \_\_\_ Apply splints and temporary casts

\_\_\_ \_\_\_ \_\_\_ Patient Education

\_\_\_ \_\_\_ \_\_\_ Provide information related to exercise, diet, etc. use of med equipment, ROM, ADL

\_\_\_ \_\_\_ \_\_\_ Develop individualized patient teaching plans based on patient needs

\_\_\_ \_\_\_ \_\_\_ Develop individualized patient teaching plans based on scope of orthopaedic needs

\_\_\_ \_\_\_ \_\_\_ Special/Other Requests:

\_\_\_ \_\_\_ \_\_\_ Order equipment used in the course of general orthopaedic practice

— — — Request PT, LRC, and/or home therapy evaluations in scope of  
orthopaedic service

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



LANE REGIONAL MEDICAL CENTER  
NURSE PRACTITIONER - PHYSICIAN= S ASSISTANT  
DELINEATIONS

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

Check One: Nurse Practitioner \_\_\_\_\_ Physician Assistant \_\_\_\_\_

To be eligible to apply for privileges in Nurse Practitioner/Physician Assistant privileges, the applicant must meet the following qualifications:

Education/

**Training:** Documented successful completion of an accredited NP or PA program and completion of training for the procedures for which privileges are sought.

**Licensure:** Have a current license, certification, or registration to practice in the State of Louisiana. Have current certification in ACLS and PALS.

Supervising physician must be available at all times to co-sign charts as required by state law.

**Experience:** Documentation of provision of services for at least 50 patients in the past twelve (12) months.

**Reappointment:** Satisfactory Performance Improvement findings at Lane Regional Medical Center/ or primary hospital of practice. Provide documentation showing evidence of providing services for at 50 patients annually over the reappointment cycle. Continuing education as required by licensing body.

*NP - A COPY OF PRACTICE PROTOCOL AGREEMENT MUST BE SUBMITTED WITH APPLICATION.*

SPONSORING PHYSICIAN'S NAME (S): (Please Print) In the absence of primary sponsoring physician, list physician who will be covering NP/PA. **At no time can NP/PA be without physician back-up.**

Primary \_\_\_\_\_ Secondary \_\_\_\_\_

The Nurse Practitioner/Physician= s Assistant functions under the direct supervision of the sponsoring physician carrying out protocols established by the sponsoring physician as approved by the Medical Staff Executive/Bylaws Committee. The physician retains ultimate responsibility for directing the specific course of medical treatment. Any medical situation or condition that arises that is not addressed by a protocol or other physician directive is to be referred immediately to the directing physician.

Nurse Practitioners/Physician=s Assistants shall adhere to all Medical Staff Bylaws, Rules and Regulations. Failure to comply may result in withdrawal or modification of privileges for nurse practitioner/ physician assistant and sponsoring physician.

***NURSE PRACTITIONERS/PHYSICIAN=S ASSISTANTS MAY ONLY REQUEST, AND MAY ONLY BE GRANTED, PRIVILEGES WHICH HAVE ALREADY BEEN EXTENDED TO THEIR EXPLICITLY DESIGNATED SUPERVISING PHYSICIAN(S).***

**CHECK FUNCTIONS REQUESTED:**

		Requested	Approved
1.	<b>Access to Medical Records:</b>		
	A. Dictate/Write History and Physical (to be countersigned by physician within 24 hours)	_____	_____
	B. Dictate/Write Progress (to be countersigned by physician within 24 hours)	_____	_____
	C. Dictate Discharge Summaries (to be countersigned by physician within 24 hours)	_____	_____
2.	<b>Medical History and Physical: (May not serve as a substitute for a physician=s H&amp;P)</b>		
	A. Interview patient for medical history and perform physical examinations, Including medical screening exams (MSE) as required by EMTALA	_____	_____
	B. Perform Physical Exam and Evaluations	_____	_____
	1. Cardiovascular	_____	_____
	2. ENT	_____	_____
	3. Eye	_____	_____
	4. Gastrointestinal	_____	_____
	5. Genitourinary	_____	_____
	6. Neurological	_____	_____
	7. Obstetrical and Gynecology (including pelvis exam)	_____	_____
	8. Pediatrics	_____	_____
	9. Respiratory	_____	_____
	10. Skeletal	_____	_____
3.	<b>Medical Orders/Protocols:</b>		
	A. Initiate established protocols approved by the Medical Staff Executive/ Bylaws Committee for medical treatment and transcribe standing orders (to be countersigned by physician within 24 hours)	_____	_____
	B. Perform or assist in the performance of laboratory and patient screening procedures to include the ordering and interpreting diagnostic laboratory tests and radiological studies (to be countersigned by physician within 24 hours)	_____	_____
4.	<b>Rounds on Patients (not to substitute for physician=s daily rounds)</b>		_____
5.	<b>Routine Therapeutic Duties:</b>		
	A. Administer injections (subcutaneous, intramuscular intravenous), local anesthesia, may include digital block	_____	_____
	B. Cleanse and dress wounds	_____	_____
	C. Suture minor wounds and lacerations	_____	_____
	D. Remove sutures/staples	_____	_____

- E. Insert and change Foley catheters \_\_\_\_\_
- F. Insert nasogastric tubes \_\_\_\_\_
- G. Administer IV fluids (under physician=s order) \_\_\_\_\_
- H. Order medications & therapies \_\_\_\_\_
- I. Reduction of toe or finger dislocation \_\_\_\_\_

- J. Minor burn care \_\_\_\_\_
- K. Nail trephaning \_\_\_\_\_
- L. I & D abscesses \_\_\_\_\_

**6. Patient Education**

- A. Provide information related to: exercise, diet, tobacco and alcohol intake, range of motion, use of crutches or walker, activities of daily living \_\_\_\_\_
- B. Develop individualized patient teaching plans based on patient needs \_\_\_\_\_

**DUTIES NOT ALLOWED: LUMBAR PUNCTURES, SPINAL TAPS, PARACENTESIS, THORACENTESIS, BONE MARROW ASPIRATION OR 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. I understand that in exercising any clinical privileges granted, I am constrained by hospital policies and the medical staff bylaws, rules and regulations.

\_\_\_\_\_  
Signature - Applicant

\_\_\_\_\_  
Signature - Primary Sponsoring Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature - Secondary Sponsoring Physician

**Credentials Committee Recommendation**

The Credentials Committee has reviewed the requested clinical privileges and supporting documentation for the above-named applicant and makes the following recommendation(s):

- 1. Recommend all requested privileges
- 1. 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