



Ville Platte/Eunice

Surgical ENT-Allergy Technician

REQUEST FOR CLINICAL PRIVILEGES DELINEATION & RECORD OF PRIVILEGES GRANTED

Name: _____ Sponsoring MD: _____

- Initial Privileges** (Initial Appointment) **Renewal of Privileges** (Reappointment)

Please check the procedure/diagnosis for which you are making application:

<i>Requested</i>	<i>PROCEDURE/PRIVILEGE</i>	<i>Granted</i>	<i>Not Granted</i>
	Correctly identify of the patient.		
	Monitor patients undergoing ENT surgical procedures in order to perform MQ testing for allergies.		
	Maintain sterile field/sterility during testing.		
	Demonstrate the appropriate technique to prepare arms for allergy testing.		
	Apply controls to upper arm and monitor for ten (10) minutes.		
	Measure wheals		
	Identify if positive Histamine, then proceed with prick testing.		
	Apply prick testing to bilateral forearms and monitor for twenty (20) minutes.		
	Measure pricks to determine dose for intradermal testing.		
	Perform intradermal testing on bilateral upper arms and observe for ten (10) minutes.		
	Interpret results and determine end-points after measuring wheals.		
	Notify parent/guardian of possible delayed reactions.		
	Verify allergy positive patients have Epi-pen/Twinject prescription.		
	Verify allergy positive patients knowlegde on use of Epi-pen/Twinject in case of reaction at home.		
	Instruct parent/guardian to call with any reactions or questions.		
	Verify followup appointment is made with ENT		
	Participate in responding to emergency situations		
	Demonstrate organizational skills		
	Demonstrate professional attitude		
	Other (please list):		

I hereby request approval for privileges requested as defined above.

Signature of Applicant

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

Signature of Sponsoring Physician

Printed Name of Sponsoring Physician



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