Ville Platte/Eunice

AUDIOLOGY

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:

Requested	PROCEDURE/PRIVILEGE	Granted	Not Granted
	Correctly identify of the patient.		
	Performs appropriate universal precautions/sanitation procedures		
	Selects patient and properly positions infant for testing.		
	Conduct infant hearing screenings		
	Insert probe into infant's ear by pulling up on pinna; position cord appropriately		
	Evaluate and adjusts fit as neccesary		
	Verifies stimulus light and low noise light is lit; checks for debris		
	Complete White Hearing Screening forms		
	Complete OPH Newborn Hearing Screening forms		
	Refer and complete appointment letter if infant needs further testing.		
	Complete appointment book with proper patient documenation if infant is referred.		
	Inform parents of results of testing.		
	Inform parents of scheduled referral appointment if necessary.		
	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

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____
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

Ville Platte/Eunice

Reappointment Activity/Quality Verification Form

I, (print)____, understand that to qualify for reappointment to the Medical Staff of Mercy Regional Medical Center/Acadian Medical Center (A campus of Mercy Regional Medical Center, I must provide evidence of a minimum of 24 patient activities (i.e., admissions/consultations/surgeries/procedures) during the past 2 year period to be able to demonstrate current clinical competence.

If I have not met the minimum case requirement at Mercy Regional Medical Center, I understand it is **my responsibility** to obtain appropriate verification from the hospital where I more actively practice and can provide evidence of a minimum of 24 patient activities (i.e., admissions/consultations/ surgeries/procedures) during the past 2 year period for the purpose of demonstrating current clinical competence. I hereby consent to the release of the requested information below for purposes of appointment/reappointment to the Medical Staff of Mercy Regional Medical Center.

Appropriate verification is:

• Completion of the lower section of this form by a hospital's representative which must be returned directly from the Facility completing the information via mail or facsimile:
Attention: Credentialing/Fax: (337)-580-7501.

_______________________________   ___________________________

Physician Signature   **Date**

**************************BELOW SECTION FOR FACILITY TO COMPLETE*******************

I, (print) ______________________________, verify that the above named physician has had the following patient activities at this facility during the past two (2) year period.

• Upon request of the above named practitioner, the following information is provided for the past 2 year period:

Number of admissions ________ **Number of consultations** ________ **Number of procedures** ________

Number of deaths ________ **Infection rate** ________ **Weeks/Days suspended for delinquent charts** ________

• Provide information on actions taken as a result of peer review activities. These include:

_____**Surgery Case Review** ____ **Utilization Review** ____ **Medical Record Review**

____ **Drug Utilization** _____ **Blood Utilization** ____ **Risk Management** ____ **Case Management Monitoring**

****Explain if any are checked (attach additional paper as needed):**

____

Signature: ____________________________ **Title:** ______________________ **Date:** _______________________

Facility: ____