



**Ville Platte—Eunice**

**REQUEST FOR CLINICAL PRIVILEGES & RECORD OF PRIVILEGES GRANTED**

1. **NAME** \_\_\_\_\_

2. **Areas of Practice**

Attached is my request(s) for those clinical privileges in the following areas of practice for which by training and experience I have current competence and which I wish to exercise at Mercy Regional Medical Center and /or Acadian Medical Center (A campus of Mercy Regional Medical Center).

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anesthesiology     | <input type="checkbox"/> Dermatology             | <input type="checkbox"/> Orthopedic/Traumatic       |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Dental                  | <input type="checkbox"/> Otolaryngological/Neck     |
| <input type="checkbox"/> Medicine           | <input type="checkbox"/> Neurology               | <input type="checkbox"/> Plastic/Maxillofacial/Oral |
| <input type="checkbox"/> Surgery            | <input type="checkbox"/> Abdominal               | <input type="checkbox"/> Rectal                     |
| <input type="checkbox"/> Nuclear Medicine   | <input type="checkbox"/> Breast                  | <input type="checkbox"/> Thoracic                   |
| <input type="checkbox"/> Obstetrics         | <input type="checkbox"/> Gynecological           | <input type="checkbox"/> Urological                 |
| <input type="checkbox"/> Pathology          | <input type="checkbox"/> Neurosurgical           | <input type="checkbox"/> Vascular                   |
| <input type="checkbox"/> Pediatrics         | <input type="checkbox"/> Ophthalmic              | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Psychiatry         | <input type="checkbox"/> Family/General Practice | <input type="checkbox"/> Podiatry                   |
| <input type="checkbox"/> Radiology          | <input type="checkbox"/> Optometry               | <input type="checkbox"/> Physician Assistant        |

Special Procedures – Non-Specialty Specific (K-6)

3. **Subject to Consultation Requirements and Other Policies**

I understand that in exercising any clinical privileges granted, I am constrained by relevant Hospital and Medical Staff policies requiring consultations for difficult diagnoses, conditions of extreme severity, and procedures/conditions which are beyond my area of specialization and expertise, by Hospital policies concerning the types of patients for whom it does not have appropriate resources (facilities, equipment or personnel) to treat except on an emergency basis, and by such special policies as may from time to time be adopted.

4. **Emergency Situations**

I also understand that it is not necessary to request emergency clinical privileges; that an emergency is deemed to exist whenever serious permanent harm or aggravation of injury or disease is imminent; or the life of the patient is in immediate danger, and any delay in administering treatment could add to that danger; that in such emergency I am authorized and will be assisted to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by my license but regardless of department affiliation, staff category or level of privileges; and that if I provide services to a patient in an emergency, I am obligated to utilize appropriate consultative assistance when available and to arrange for appropriate follow-up care.

5. **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**6. Conditions/Exceptions**

The following clinical privileges have been approved by the Board of Trustees with the following conditions or exceptions:

<b>PRIVILEGE</b>	<b>CONDITION/EXCEPTION</b>

**7. APPROVALS:**

**SERVICE CHIEF** \_\_\_\_\_ **DATE** \_\_\_\_\_

**MEC** \_\_\_\_\_ **DATE** \_\_\_\_\_

**BOARD** \_\_\_\_\_ **DATE** \_\_\_\_\_



**Ville Platte/Eunice  
DENTAL CORE PRIVILEGES**

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

REQUESTED	PROCEDURE/DIAGNOSIS	EXEC/CRED COMM.		B.O.D.	
		RECC.	NOT	APPROVE	DENIED
	<b>REHABILITATION OF DENTAL ARCHES</b>				
	Operative restorations				
	Crown and bridge preparation				
	Prosthetic replacement of teeth				
	Implantation of teeth				
	<b>ORAL PROSTHESIS</b>				
	Oral prosthesis for malformations of the face, jaws, and mouth.				
	a. Congenital				
	b. Pathological				
	c. Traumatic				
	Implant dentures				
	<b>EXTRACTION OF TEETH</b>				
	Single, uncomplicated extractions				
	Multiple, uncomplicated extractions				
	Surgical removal of impacted teeth				
	Surgical removal of embedded teeth				
	<b>INTRA ORAL SURGERY</b>				
	Root resections				
	Alveolectomy				
	Alveoplasty				
	Torus palatinus				
	Torus mandibularis				
	Minor lacerations				
	Simple intra oral biopsy				
	Benign tumors				
	Minor cysts				
	Major extensive cysts				
	Minor infections				
	Major infections				
	Incision and drainage				
	Salivary duct surgery				
	Tongue surgery				
	Ranula				
	Caldwell-luc procedure for root tip removal from antrum				



**Ville Platte/Eunice  
DENTAL CORE PRIVILEGES**

REQUESTED	PROCEDURE/DIAGNOSIS	EXEC/CRED COMM.		B.O.D.	
		RECC.	NOT	APPROVE	DENIED
	<b>EXTRA ORAL SURGERY</b>				
	Minor infections				
	Major infections				
	Minor lacerations				
	Major lacerations				
	Minor cysts				
	Lip surgery (traumatic)				
	Benign tumors				
	Incision and drainage				
	<b>FRACTURES OF THE JAW AND ASSOCIATED STRUCTURES</b>				
	Maxilla, closed reduction				
	Maxilla, open reduction				
	Mandible, closed reduction				
	Mandible, open reduction				
	Zygoma, closed reduction				
	Zygoma, open reduction				
	<b>OTHER</b>				
	TMJ dislocation, closed reduction				
	Splinting of traumatized teeth				
	Treatment of TM dysfunction				
	Stabilization of avulsed teeth				
	Consultation				

I hereby apply for privileges as defined above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant



**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

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 505-346-0829 or 337-580-7729.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

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: \_\_\_\_\_

Facility: \_\_\_\_\_ 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:

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\_\_\_\_\_  
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