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).

___Anesthesiology
___Emergency Medicine
___Medicine
___Surgery
___Nuclear Medicine
___Obstetrics
___Pathology
___Pediatrics
___Psychiatry
___Radiology
___Dermatology
___Dental
___Neurology
___Abdominal
___Breast
___Gynecological
___Neurosurgical
___Ophthalmic
___Family/General Practice
___Optometry
___Orthopedic/Traumatic
___Otolaryngological/Neck
___Plastic/Maxillofacial/Oral
___Rectal
___Thoracic
___Urological
___Vascular
___Other
___Podiatry
____ 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:

PRIVILEGE	CONDITION/EXCEPTION

7. APPROVALS:

SERVICE CHIEF ____ **DATE**_____________

MEC ____ **DATE**_____________

BOARD ____ _ **DATE**_____________

MERCY
REGIONAL MEDICAL CENTER

Ville Platte—Eunice

Emergency Medicine
Core Privileges

Criteria for Appointment:

Basic Education: MD or DO
Minimal formal training: Applicants must have successfully completed or be enrolled in an accredited residency program If applicants have not completed an emergency medicine or combined program, and/or have no current board certification in emergency medicine, internal medicine, family practice or pediatrics, they must be able to document training and experience in emergency medicine or a related specialty that allows them to evaluate and initially manage and treat all patients who seek emergency care.

Core Privileges-Emergency Medicine *Requested* ________ *Granted* __________

Privileges include being able to assess, work up, and provide initial treatment to patients who present with any illness or injury, condition, or symptom in the ED. Core privileges also include but are not limited to the following:

- Perform historical and physical examinations, including ordering and interpreting diagnostic studies
- Provide services necessary to ameliorate minor illnesses or injuries
- Stabilize patients who present with major illnesses or injuries
- Administer appropriate medications
- Assess patients in order to determine whether more definitive services are necessary
- Request consultations and technical procedures to be performed by other physicians and qualified consultants/technicians
- Arrange appropriate follow-up or referral as required
- Manage the EMS medical coordination of the acutely ill or injured patient

Special Privileges-Emergency Medicine

- Pelvic ultrasound *Requested* ________ *Granted* __________
- Echocardiography *Requested* ________ *Granted*__________
- Ultrasound of subcutaneous tissues for foreign body localization *Requested* ________ *Granted*__________
- Fiberoptic laryngoscopy *Requested* ________ *Granted*__________
- Flexible sigmoidoscopy *Requested* ________ *Granted*__________
- Thoracentesis *Requested* ________ *Granted*__________
- Culdoncentesis *Requested* ________ *Granted*__________
- Suprapubic bladder catherization *Requested* ________ *Granted*__________
- Department administration *Requested* ________ *Granted*__________

____________________________ ____________________________
Applicant Signature Date

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:

____

____

____
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