MEDICAL STAFF of TURQUOISE LODGE HOSPITAL

REQUEST FOR SPECIFIC CLINICAL PRIVILEGES

Applicant's Name (Print): ____

Highest Level of Licensure: ☐ MD/DO ☐ PhD/PsyD (psychologist) ☐ CNP/RNCS

☐ LPCC ☐ LADAC ☐ LISW (Social Worker)

☐ OTHER _______________ ☐ Prescribing/Cond. Prescribing Psychologist

Requests for ***new*** or ***additional*** privileges ***must*** be accompanied by supporting documentation to verify your qualification. Please refer to the enclosed **Privilege Criteria Sheet.**

Please indicate privileges being requested for:

☐ **Adults (A)** 18 and over	☐ Yes	☐ No
☐ **Adolescents (T) – 12 to 17 years of age**	☐ Yes	☐ No
☐ **Children (C) – 11 years of age and under**	☐ Yes	☐ No
☐ **Long Term Care (LTC)/Geriatrics**	☐ Yes	☐ No

Other(s)

☐ ____

☐ ____

☐ ____

☐ ____

☐ ____

Specific Privileges for which application is made: (check as many as apply)

☐ *PSYCHIATRY*

- ☐ Screening/Admission Evaluation
- ☐ Psychiatric Assessment
- ☐ Psychiatric Diagnosis
- ☐ Formulation of Treatment Plans
- ☐ Psychopharmacology
- ☐ Discharge of Patients
- ☐ Individual & group therapy
- ☐ Neuropsychiatric Assessment, Diagnosis and Treatment
- ☐ Consultation(s)
- ☐ Other(s) ________________

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☐ *PSYCHOLOGY*

- ☐ Screening/Admission Evaluation
- ☐ Psychological Assessment
- ☐ Psychiatric/Psychological Diagnosis
- ☐ Formulation of Treatment Plans
- ☐ Psychological Testing
- ☐ Psychotherapeutic Treatment
- ☐ Behavior Therapy
- ☐ Substance Abuse Treatment
- ☐ Neuropsychological Testing
- ☐ Consultation
- ☐ Other (s) ________________

☐ Prescribing/Medical Psychology
(including Conditional)

- ☐ Lab Testing as per Statute
- ☐ Psychopharmacology
- ☐ Psychiatric Assessment
- ☐ Discharge of Patients

All prescribing in consultation with primary care providers. Medication formulary restricted per 16.22.27.8A NMAC.

☐ *MEDICINE*

- ☐ Screening/Admission Evaluation
- ☐ Physical Assessment
- ☐ Treatment
- ☐ Referral
- ☐ Discharge of patients
- ■ **Procedure(s)**
- ☐ Order/interpret Lab. Testing
- ☐ Primary Control of bleeding
- ☐ Starting IV fluids
- ☐ Anoscopic Examination
- ☐ Interpret Electrocardiogram
- ☐ Suture minor and major lacerations
- ☐ Temporary Splinting of displaced and undisplaced fractures
- ☐ Reduction of simple dislocations
- ☐ Treatment of 1st and 2nd degree Burns
- ☐ Anterior nasal packing for Epistaxis
- ☐ Removal of corneal foreign body
- ☐ Local block anesthesia
- ☐ Incision and drainage of abscess
- ☐ Other (s) ________________

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Applicant's Signature: ________________________________ Date: ____________

FOR MEDICAL STAFF OFFICE USE ONLY

INITIAL REVIEW
Recommended for:
☐ **A** ☐ **T** ☐ **C** ☐ **LTC**

Need Additional Information for:
☐ **A** ☐ **T** ☐ **C** ☐ **LTC**

Comments: ________________________________

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Clinical Reviewer: ________________ Date: ________

Committee Chair: ________________ Date: ________

SUBSEQUENT REVIEW (Use as needed)
Information Requested for:
☐ **A** ☐ **T** ☐ **C** ☐ **LTC**

Recommended for:
☐ **A** ☐ **T** ☐ **C** ☐ **LTC**

Comments: ________________________________

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Clinical Reviewer: ________________ Date: ________

Committee Chair: ________________ Date: ________

TURQUOISE LODGE HOSPITAL

STATEMENT OF HEALTH STATUS

This is to certify that I am in adequate physical and mental health to deliver my professional responsibilities and have no current illicit drug or alcohol problems.

________________________________ ____________________
Signature **Date**

____
Print Name

Turquoise Lodge Hospital • PO Box 80810
Albuquerque, New Mexico 87198
(505) 841-8978 • FAX: (505) 841-8977

EVIDENCE OF COVERAGE

MEMORANDUM NUMBER:RMD-EOCFY12-00441

This Evidence of Coverage is used as a matter of information only and confers no rights upon the Certificate Holder. This Evidence of Coverage does not amend, extend, or alter the coverage afforded by the insurance policy(ies) for the type(s) of coverage listed below.

CERTIFICATE HOLDER INFORMATION

INSURED: State of New Mexico **LOSS PAYEE: TO WHOM IT MAY CONCERN**

Turquoise Lodge Hospital/NMDOH
5901 Zuni Rd. SE
Albuquerque, NM 87108

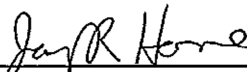
Dates: 7/1/11 to 6/30/12

Coverage Period	**Effective:**	**7/1/11, 12:01 AM**	**Expires : 7/1/12, 12:01 AM**

This is to certify that the State of New Mexico maintains the insurance listed below for the period indicated. Notwithstanding any requirement, term or condition of any contract or other document with respect to which this Evidence of Coverage may be used or may pertain, the coverages afforded by the Evidence of Coverage described herein are subject to all terms, exclusions, and conditions of the insurance policy(ies) to which this Evidence of Coverage pertains.

Type of Coverage	Limit of Liability/Coverage
General Liability Medical Malpractice	$1,050,000.00 Per Occurrence (Aggregate, see Statutes

Should any of the above coverages for the Covered Party be changed or withdrawn prior to the expiration date issued above, the State of New Mexico will mail 30 days written notice to the Certificate Holder, but failure to mail such notice shall impose no obligation or liability of any kind upon the State of New Mexico, its agents, or representatives. If you have any questions, contact:

Authorized Representative:		
Date Issued:	7/1/11	Jay R. Hone, Director, Risk Management Division , GSD Risk Management Division