Hospital Logo

Hospital Name

Hospital Address

**Application for Clinical Privileges – Physician Assistant**

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| Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff Category: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Effective from \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Request all privileges desired by checking the applicable requested box.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Request | Not Requested |  | Granted | Not Granted |
|  |  | Admit, evaluate, diagnose, treat, medically manage and provide consultation to patients of all ages, with a wide variety of illnesses, diseases, injuries, and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, integumentary, nervous, female reproductive, and genitourinary systems within the medical staff approved protocols and within the scope of practice of the supervising physician. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills. Direct or personal supervision by a physician is not required when the Physician Assistant is performing services. The supervising physician may provide direction and supervision telephonically or electronically unless he physician is requested to come to the Hospital. |  |  |
|  |  | **Procedures: Remove those procedures not within capabilities and capacities of Hospital or within the medical staff approved protocols** |  |  |
|  |  | Local Anesthetic techniques including peripheral nerve blocks and trigger point injections |  |  |
|  |  | Simple skin biopsy or excision of foreign body removal |  |  |
|  |  | Perform and interpret emergent, focused or investigational ultrasound |  |  |
|  |  | Treatment of burns, superficial and partial thickness |  |  |
|  |  | Wound closure and debridement |  |  |
|  |  | Incision and drainage or aspiration of superficial soft tissue mass |  |  |
|  |  | Management of epistaxis including placement of posterior nasal hemostatic packing |  |  |
|  |  | Rhinolaryngoscopy |  |  |
|  |  | Stabilization of non-displaced closed fractures and uncomplicated dislocations including skeletal immobilization techniques |  |  |
|  |  | EKG interpretation |  |  |
|  |  | Stress testing - treadmill |  |  |
|  |  | Removal non-penetrating foreign body from eye, nose or ear |  |  |
|  |  | Crede or suprapubic bladder tap |  |  |
|  |  | Insertion of temporary pacemaker |  |  |
|  |  | **Gynecology and Reproductive Health: Remove those procedures not within capabilities and capacities of Hospital or within the medical staff approved protocols** |  |  |
|  |  | Pap Smear and endocervical culture |  |  |
|  |  | Biopsy of cervix, endometrium, vulva including drainage of vulvar abscess |  |  |
|  |  | Excision/biopsy of vulvar lesions |  |  |
|  |  | IUD removal |  |  |
|  |  | **Complex Procedures: Remove those procedures not within capabilities and capacities of Hospital or within the medical staff approved protocols** |  |  |
|  |  | Arthrocentesis and joint injection |  |  |
|  |  | Paracentesis Including tap and lavage |  |  |
|  |  | Arterial puncture or line placement |  |  |
|  |  | Central venous catheter placement |  |  |
|  |  | Placement of Swann-Ganz |  |  |
|  |  | Elective cardioversion |  |  |
|  |  | Thoracentesis and chest tube insertion/removal |  |  |
|  |  | Lumbar puncture |  |  |
|  |  | Intubation (Emergent) or other emergent airway measures |  |  |
|  |  | Ventilator Management - emergency temporary |  |  |
|  |  | **Newborn Services: Remove those services not within capabilities and capacities of Hospital or within the medical staff approved protocols** |  |  |
|  |  | Attendance at anticipated normal newborn deliveries |  |  |
|  |  | Care of stable neonate in newborn nursery including H & P |  |  |
|  |  | Circumcision |  |  |
|  |  | **Obstetrics (Uncomplicated) Privileges**: **Remove those privileges not within capabilities and capacities of Hospital or within the medical staff approved protocols** |  |  |
|  |  | Management of pre-natal care In health women where a normal term single birth delivery is the expected outcome including the use of OB ultrasound for fetal position and presentation |  |  |
|  |  | Management of post-partum care |  |  |
|  |  | Oxytocin challenge test |  |  |
|  |  | Management of normal labor (not less than 36 weeks or more that 42 weeks) where vertex delivery of a single normal newborn is the expected outcome including the use of fetal monitoring |  |  |
|  |  | Induction or augmentation of labor |  |  |
|  |  | Amniotomy |  |  |
|  |  | Episiotomy and repair of 3rd degree laceration |  |  |
|  |  | Manual removal of placenta, post-delivery |  |  |
|  |  | Pudendal and paracervical anesthesia |  |  |
|  |  | First assist at C-Sections |  |  |
|  |  | Operative delivery including low forceps or vacuum |  |  |
|  |  | Tubal ligation associated with C-section |  |  |
|  |  | Post-partum dilation and curettage |  |  |
|  |  | C-Section Delivery |  |  |
|  |  | **Endoscopy: Diagnostic Endoscopy includes biopsy and polypectomy as applicable.** **Remove those procedures not within capabilities and capacities of Hospital or within the medical staff approved protocols** |  |  |
|  |  | Anoscopy |  |  |
|  |  | Proctoscopy |  |  |
|  |  | Sigmoidoscopy |  |  |
|  |  | Colonoscopy |  |  |
|  |  | EGD without dilation |  |  |
|  |  | EGD for removal of foreign body |  |  |
|  |  | EGD for dilation of stricture |  |  |
|  |  | **Moderate Sedation:** **Remove this privilege not within capabilities and capacities of Hospital or within the medical staff approved protocols** |  |  |
|  |  | Moderate/Conscious Sedation |  |  |
|  |  | Other Privileges Desired (Not Listed Above) |  |  |
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**Signature of Applicant:**

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I am entitled to perform and that I wish to exercise at (Insert Name of Hospital).

I also understand that by making this request I am bound by the applicable Medical Staff Bylaws and/or policies of (Insert Name of Hospital). I also attest that my professional liability insurance covers the privileges I have requested.

I understand that it is my responsibility to provide (Insert Name of Hospital) with documentation of my education, training, current experience and information regarding the number of services and procedures I have performed in order to assist the Medical Staff in the determination of competency or continued competency.

I affirm that I will obtain a consultation with a qualified medical staff member when it is in the best interest of the patient and/or when my expertise does not meet the clinical needs of the patient.

Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws and related documents.

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**Signature of Applicant Date**

**Medical Staff/Credentials Committee Recommendations – Privileges**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s): Please check the applicable box(es)

|  |  |
| --- | --- |
|  | Recommend all requested privileges |
|  | Do not recommend any of the requested privileges |
|  | Recommend privileges with the following conditions/modifications/deletions (listed below) |

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| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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**Medical Staff/Credentials Committee Date**

**Board of Directors Determination**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following determination(s): Please check the applicable box(es).

|  |  |
| --- | --- |
|  | Approve all requested privileges |
|  | Approve none of the requested privileges |
|  | Approve the following privileges with the following conditions/modifications/deletions (listed below) |

|  |  |
| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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Board of Directors Date

Hospital Name

Form Approved By:

Medical Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Board of Directors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date