Privileges for: APRN - Emergency Medicine

Request

ST. ELIZABETH - EDGEWOOD
ST. ELIZABETH - FLORENCE
ST. ELIZABETH - FT. THOMAS
ST. ELIZABETH - GRANT CO. (Surgical & other invasive procedures requiring general anesthetic are not offered)

Check below for the site-specific privileges requested:

_____ Edgewood, Covington and Grant County

_____ Florence and Ft. Thomas

MEC Approval: November 18, 2010, Revised 9.25.2014, Rev. 5.28.2015

Board Approval: January 10, 2011, Revised 11.3.2014, Rev. 9.14.2015

_____ _____
Department/Section Chair Signature **Date**

Nursing Administration Approval

_____ _____
Sr. V.P. of Nursing or Designee Signature **Date**

Must be sponsored by a physician who is a member of the Medical Staff of St. Elizabeth Healthcare

SUPERVISING PHYSICIAN ENDORSEMENT: As the applicant's supervising physician, I have read the foregoing application and have indicated by my initials and date above the appropriate levels of supervision I will employ to promote the safety and care of our patients at a generally recognized professional level of quality and efficiency. I acknowledge my continuing responsibility for supervising this applicant until such time as he or she secures another supervising physician.

I agree that the use of my electronic signature below indicates my intent to sign this document as if it were my original handwritten signature.

Last 4 digits of S.S.N._____

_____ _____
Sponsoring Physician Signature **Date**

MINIMUM REQUIREMENTS

Current license to practice in Kentucky as a Nurse Practitioner

PRIVILEGES REQUESTED

Privileges for: APRN - Emergency Medicine

Request

Pursuant to Bylaws Section 6.1.4, practitioners may exercise the privileges requested and awarded below only at facilities where St. Elizabeth Healthcare offers those services. Note: For each privilege that the practitioner requests below, the supervising physician must, prior to submission to the section chair, indicate the level of supervision that he or she intends to exercise by typing the level of supervision into the COMMENTS box for each requested privilege below:

o An emergency physician is always on-site in the ED. Patient care will be in accordance with established patient care protocols and corresponding supervision requirements.
o For privileges requiring on-site supervision only, type the level of supervision into the COMMENTS box.

o For privileges requiring on-site supervision and practitioner-physician staffing, type the level of supervision into the COMMENTS box.

If a supervision level is not offered, the MEC and Board have determined that that level of supervision may not be employed.

DEFINITIONS OF LEVELS OF SUPERVISION:

Direct Supervision: This means the supervising physician is sufficiently nearby that the AHP may verbally summon the supervisor's help if needed when the AHP is performing a function requiring direct supervision. Although the physician may be performing some other task at the time, the supervising physician must be able to immediately provide direction and assume the performance of the task if difficulties arise. This does not require that the physician is actually in sight of the AHP or watching "over the shoulder" of all AHPs as may be required during the training period of Physician Assistants to ensure that the Physician Assistant is competent to perform the task.

On-site supervision: Requires the physical presence of the supervising physician in the same location (i.e. the hospital) as the AHP, but does not require the physical presence in the same room.

DESCRIPTION OF CORE PRIVILEGES

Core privileges as an Emergency Department Nurse Practitioner include the care, treatment or services listed immediately below. I specifically acknowledge that my licensure and certification alone do not necessarily qualify me to perform all core privileges or assure competence in all clinical areas. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below. Please line through and initial any specific privileges within a checked privilege group that you are not requesting.

_____ I am privileged to collaborate with more than one physician group.

_____ Performance of histories and physicals limited in scope to the supervising physician's area of expertise and subject to the countersignature requirements of the Rules and Regulations (-0- or -D-)

_____ Performance of medical screening examinations (-0- or -D-)

_____ Record medication, diagnostic and therapeutic verbal orders given by the supervising physician, subject to the verification, read-back and countersignature requirements of the Rules and Regulations (-0- or -D-)

_____ Make chart entries (subject to the countersignature requirements of the Rules and Regulations) (-0- or -D-)

_____ Write orders within the AHP's scope of practice, as delegated by the supervising physician acting within his or her area of expertise (-0- or -D-)

_____ Prescribe non-scheduled pharmacologic agents within the scope of the supervising physician's area of expertise and training (-0- or -D-)

_____ Make appropriate referrals to other health professionals and community agencies (-0- or -D-)

_____ Order appropriate diagnostic tests within the scope of the supervising physician's area of expertise and training (-0- or -D-)

_____ Patient counseling and patient instruction based on Physician orders (-0- or -D-)

_____ Administer injections (subcutaneous, intramuscular, intravenous) and immunizations (-0- or -D-)

_____ Nasogastric intubation (-0- or -D-)

_____ Start IVs (-0- or -D-)

_____ Administration of local anesthetic (-0- or -D-)

_____ Cleansing and dressing wounds and removal of sutures (-0- or -D-)

Privileges for: APRN - Emergency Medicine

Request

ADDITIONAL PRIVILEGES: In addition to the core privileges requested above, I am requesting the additional privileges below. In addition to meeting the minimum requirements for core privileges, applicants must meet all "Additional Requirements" listed for each privilege below and provide documentation (training course certification, letter from supervisor and/or medical staff leader) demonstrating appropriate education, training, ability and current competence. Credentialing bodies or persons may request additional documentation or information. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below.

_____ Wound care, including foreign body removal, incision and drainage of abscesses and use of sutures, staples or skin adhesives (-0- or -D-)

_____ Digital blocks (-0- or -D-)

_____ Splinting of extremity fractures or specifying the type of splint to be used (-0- or -D-)

_____ Removal of superficial foreign body from the eye without the use of the slit lamp and uncomplicated foreign body removal from the nose, ear, skin/soft tissue and vagina (-0- or -D-)

_____ Removal of superficial foreign body from the eye using the slit lamp

_____ Reduction of small joint dislocations (-0- or -D-)

_____ Reduction of partial subluxation of radial head (-0- or -D-)

_____ Prescription of controlled substances within scope of authority and within the scope of the supervising physician's area of expertise and training (REQUIRED: KY Board of Nursing eligibility and CAPA-CS, DEA) (-0- or -D-)

Please submit collaborative practice agreement with this document.

I agree that the use of my electronic signature below indicates my intent to sign this document as if it were my original handwritten signature.

Applicants Signature: _____ **Date:** _____