Privileges for: APRN/PA - Radiology

Request

Document review: MEC November 18, 2010; Revised 9.25.2014; Board January 10, 2011; Revised June 27, 2013, December 19, 2013, Revised 11.3.2014

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

_____ _____
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

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._____

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.

_____ _____
Sponsoring Physician Signature **Date**

MINIMUM REQUIREMENTS

Current License in Kentucky as a Physician Assistant or Nurse Practitioner

PRIVILEGES REQUESTED

Privileges for: APRN/PA - Radiology

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 the requested privilege below:

- **For privileges that may be exercised via phone availability (and not more than 30 minutes travel time away), type "A" in the COMMENTS box.**
- **For privileges requiring on-site supervision, type "O" in the COMMENTS box.**
- **For privileges requiring direct supervision, type "D" in the COMMENTS box.**

The Kentucky Board of Medical Licensure requires a physician assistant to have 18 months of continuous experience before the Board approves off-site supervision. Direct or on-site supervision will be required at all times during a physician assistant's eighteen months of continuous practice unless a waiver has been requested by a supervising physician and approved by the Board. A primary or alternate supervising physician will have to be, at a minimum, on-site during a physician assistant's work shift during this eighteen month period.

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.

Available by phone: The supervising physician must be continuously available for direct communication with the AHP and must be in a location that, under normal conditions, is not more than 30 minutes travel time from the AHP's location.

DESCRIPTION OF CORE PRIVILEGES

Core privileges as a Radiology Physician Assistant or 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 (-A- or -0-)

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

_____ Conduct rounds, make chart entries (subject to the countersignature requirements of the Rules and Regulations) and prepare discharge summaries for supervising Member signature (-A- or -0-)

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

_____ Assist in radiologic interventions/procedures (-0-)

_____ Provide pre- and postoperative intervention/procedure care (-A- or -0-)

_____ Cleanse and debride wounds and suture lacerations and remove sutures and staples (-A- or -0-)

_____ Order diagnostic testing (-A- or -0-)

_____ Provide counseling / education (-A- or -0-)

_____ Prescribe non-scheduled pharmacologic agents within the scope of the supervising physician's area of expertise and training (Kentucky Board of Nursing eligibility plus CAPA-NC form required (-A- or -0-)

Privileges for: APRN/PA - Radiology

Request

_____ Make appropriate referrals (-A- or -0-)

II. 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.

_____ Preliminary interpretation of DEXA scan (-A-) - (Certification required) - (doesn't require 20 cases) - Supervising Radiologist reviews/signs off on report.

_____ Image guided biopsies (i.e. thyroid, liver, bone marrow, superficial soft tissue masses) - each type of biopsy requires 20 proctored cases under direct supervision

Direct supervision of 20 cases is presently required before "onsite supervision" (O) or "available by phone" (A) is granted.

_____ Central line placement (includes acute hemodialysis catheter placement, tunneled central line placement (-D- or -0- or -A-) 30 additional cases reviewed by supervising physician for (- A -)

_____ PICC line placement and management (-D- or -A-); (no additional cases needed)

_____ Imaging guided biopsies (-O-)

_____ Lumbar punctures with or without injection of contrast material (-D- or -O- or -A-) ; 10 additional cases reviewed by supervising physician for (-A-)

_____ Myelography (-O- or -D-) ; 5 additional cases reviewed by supervising physician for (- O -)

_____ Thoracentesis under image guidance (-D- or -O- or -A-) ; 30 additional cases reviewed by supervising physician for (- A -)

_____ Paracentesis under image guidance (-D- or -O- or -A-) ; 30 additional cases reviewed by supervising physician for (- A -)

_____ Joint injection and aspiration (-D- or -O- or -A-) ; 10 additional cases reviewed by supervising physician for (- A -)

_____ Chest tube, abscess tube, nephrostomy tube and biliary drainage tube follow up, management and removal (but not placement) (no additional cases needed) (-D- or -A-)

UNDER FLUOROSCOPY (radiation safety certification required)

_____ Chest port injections and injection of drains (Injection of contrast into port-a-cath and/or drains - fluoroscopic privileges required) (no additional cases need) (-D- or -A-)

Please submit collaborative practice or supervising physician 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:** _____