Privileges for: PA - Emergency Medicine

Request

ST. ELIZABETH - EDGEWOOD
ST. ELIZABETH - FLORENCE
ST. ELIZABETH - FT. THOMAS
ST. ELIZABETH - GRANT CO.

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, Revised 5.28.2015

Board Approval: January 10, 2011, Revised 11.3.2014, Revised 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

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

PRIVILEGES REQUESTED

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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 E.D. 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 superivsion into 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.

DESCRIPTION OF CORE PRIVILEGES

Core privileges as an Emergency Department Physician Assistant 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 diagnostic and therapeutic verbal orders (but not medication 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-)

__________ Administration of local anesthetic (-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 and in accordance with the PA's supervision agreement (-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-)

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

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

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

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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-)

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

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

__________ Removal of superficial foreign body from the eye without the use of a slit lamp and uncomplicated foreign body removal (-0- or -D-)

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

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

__________ Insertion of urinary catheters (-0- or -D-)

__________ Phlebotomy (-0- or -D-)

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

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

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

__________ Insertion of central lines (-0- or -D-)

__________ Intubation (- 0 - or - D -)

__________ Lumbar Puncture (- 0 - or - D -)

__________ Nasal packing (- 0 - or - D -)

Please submit supervising physician agreement with this document.

______________________________ ______________

Applicant Printed Name **Date**

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:** ______________