Privileges for: APRN - 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)

MEC Approval: November 18, 2010; Rev. 2.27.2014, 3.27.2014, 4.24.2014, 9.25.2014, 1.23.2015, 3.26.2015, 5.26.2016

Board Approval: January 10, 2011; Revised 5.5.2014, 11.3.2014, 3.2.2105, 5.4.2015, 9.12.2016

_____ _____
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 nursing in Kentucky
Successful completion of an accredited nurse practitioner training program and
Certification by Kentucky as a Nurse Practitioner

_____ I am requesting affiliation without privileges

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

PRIVILEGES REQUESTED

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:

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

Privileges for: APRN - Medicine

Request

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 AHPs to ensure that the AHP 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 Medical Nurse Practitioner include the care, treatment or services listed immediately below. I specifically acknowledge that my certification and training 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.

_____ 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 -O-)

_____ 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 (-A- or -O-)

_____ 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 -O-)

_____ 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 -O-)

_____ Patient counseling and patient instruction based on Physician orders (-A- or -O-)

_____ 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 -O-)

_____ Make appropriate referrals to other health professionals and community agencies (-A- or -O-)

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

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 provide documentation (training course certification, letter from supervising physician) 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 debridement, local anesthesia, incision and drainage of superficial abscesses and use of sutures, staples or skin adhesives, wound packing and foreign body removal (-A- or -O- or -D-)

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

_____ Fluoroscopy (Radiation safety certification required) (-O- or -D-)

FOR NEPHROLOGY

_____ Placement of dialysis catheters; Proctoring required for 10 cases (-A- or -O- or -D-)

_____ Removal of vascular catheters (-A- or -O- or -D-)

_____ Ultrasound or fluoroscopy for dysfunctional shunt (Radiation safety certification required) (-O- or -D-)

Privileges for: APRN - Medicine

Request

FOR CARDIOLOGY / NEPHROLOGY

_____ Placement central venous catheters; Proctoring required for 10 cases (-A- or -O- or -D-)

_____ Removal of central venous catheters (-0- or -D-)

_____ Arterial puncture (-A- or -O- or -D-)

_____ Arterial canulation (-0- or -D-)

_____ Peripheral PICC line placement and management - includes ELC line for ultrafiltration device to control CHF - Proctoring required for 10 cases (-A- or -O- or -D-)

_____ Assessment, monitoring and assisting patients undergoing treadmill exercise testing while under the direction of the designated physician - (Training criteria: Successful completion of an orientation in the stress lab and subsequent completion of a competency checklist and current in ACLS) (- D -)

_____ VAD Interrogation (requires completion of online training and on-site training with clinical educator) (-A- or -O- or -D-)

_____ Order extracorporeal therapies (-A- or -O- or -D-)

FOR GASTROENTEROLOGY

_____ PEG tube maintenance (-A- or -O- or -D-)

FOR MEDICAL ONCOLOGY

_____ Bone marrow biopsy (-A- or -O- or -D-) (requires documentation of 20 procedures under direct supervision)

FOR BEHAVIORAL HEALTH FOR THOSE A.P.R.N.s WITH A LIMITED SCOPE OF PRACTICE (at SEH)

_____ Group therapy

_____ One-on-one therapy

_____ Prescription of controlled substances within scope of authority and within the scope of the supervising physician's area of expertise and training (KY Board of Nursing eligiblity and CAPA-CS, DEA) (-A- or -O- 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:** _____