Regions Hospital
Delineation of Privileges
Physician Assistant

Applicant's Name:_____ _____

Last **First** **M** **Date**

Instructions: **Applicants must attach to this delineation of privileges supporting documentation attesting to his or her experience and/or formal training.**

☐**CORE I - General Privileges for New Physician Assistant (This box must be checked if you are new a graduate and desire any of the privileges listed below)** This Core is contingent upon applicant obtaining permanent registration to practice, national certification, DEA certification, filing of Physician Assistant Supervisory Agreement and Practice Setting Descriptions, all within one year of being employed. Failure to meet the foregoing requirements will result in revocation of privileges.

Privileges	Registration and Certification	Required Documentation and Experience
General core privileges include initial and ongoing assessment of the patient's medical, physical, and psychiatric status including the following: perform and document complete medical history, perform and document complete physical examination, record diagnostic impressions, write orders for diagnostic tests; activities, therapies, diet and vital signs; drugs; IV fluids; blood and blood products; oxygen; and consultation with medical staff members, instruct, educate and counsel patients on health status, results of tests, disease process, discharge summaries, and planning. Evaluate interim patient status and document in the progress notes, initiates consultation by other physicians at the direction of the supervising physician.	1) Current temporary or permanent registration to practice as a physician assistant in Minnesota **and** 2) Progressing toward National Certification * National certification by the National Commission on Certification of Physician Assistant (NCCPA) **or** * National certification by the National Board of Commission of Orthopedic Physician Assistants (NBCOPA) **and** 3) Physician Assistant-Physician Supervisory Agreement **and** 4) Practice Setting Description **and**	**New Applicants**: Two (2) letters of reference from physicians or other practitioners, familiar with the applicant's current clinical competence. At least one (1) letter must be from another Physician Assistant. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____ Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____

☐ CORE II - General Privileges for established Physician Assistant (This box must be checked if you desire any of the privileges listed below)

Privileges	Registration and Certification	Required Documentation and Experience
General core privileges include initial and ongoing assessment of the patient's medical, physical, and psychiatric status including the following: perform and document complete medical history, perform and document complete physical examination, record diagnostic impressions, write orders for diagnostic tests; activities, therapies, diet and vital signs; drugs; IV fluids; blood and blood products; oxygen; and consultation with medical staff members, instruct, educate and counsel patients on health status, results of tests, disease process, discharge summaries, and planning. Evaluate interim patient status and document in the progress notes, initiates consultation by other physicians at the direction of the supervising physician.	1) Current registration to practice as a physician assistant in Minnesota **and** 2) National Certification *Current national certification by the National Commission on Certification of Physician Assistant (NCCPA) **or** *Current national certification by the National Board of Commission of Orthopedic Physician Assistants (NBCOPA) **and** 3) Physician Assistant-Physician Supervisory Agreement **and** 4) Practice Setting Description **and**	**New Applicants**: Two (2) letters of reference from physicians or other practitioners, familiar with the applicant's current clinical competence. At least one (1) letter must be from another Physician Assistant. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____ Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____ **Reappointment Applicants**: Evaluation of current competency conducted by a Physician Assistant of your choice. Please indicate name and address of the individual whom we may contact. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____

☐ CORE III – Physician Assistant in Surgery (This box must be checked if you desire any of the privileges listed below)

This privileging section is only applicable to those applicants who have met Core I or II requirements for registration and certification and required experience and documentation in addition to the educational requirements listed below:

Privileges	Additional Educational Requirements	Required Documentation and Experience
Core III privileges for Physician Assistant in Surgery include that which is outlined in the general Physician Assistant Core I or II privileges. The Surgery Physician Assistant provides care to both pediatric and adult patients.	Same as Core I or II.	**New Applicants**: Two (2) letters of reference from physicians or other practitioners, familiar with the applicant's current clinical competence. At least one (1) letter must be from another Physician Assistant. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____ Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____ **Reappointment Applicants**: Evaluation of current competency conducted by a Physician Assistant of your choice. Please indicate name and address of the individual whom we may contact. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____

☐ **CORE IV - Physician Assistant in Orthopedics (This box must be checked if you desire any of the privileges listed below)**

This privileging section is only applicable to those applicants who have met Core I or II requirements for registration and certification and required experience and documentation in addition to the educational requirements listed below:

Privileges	Additional Educational Requirements	Required Documentation and Experience
Core IV privileges for Physician Assistant in Orthopedics include that which is outlined in the general Physician Assistant Core I or II privileges. The Orthopedic Physician Assistant provides care to pediatric and adult patients.	Same as Core I or II.	**New Applicants**: Two (2) letters of reference from physicians or other practitioners, familiar with the applicant's current clinical competence. At least one (1) letter must be from another Physician Assistant. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____ Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____ **Reappointment Applicants**: Evaluation of current competency conducted by a Physician Assistant of your choice. Please indicate name and address of the individual whom we may contact. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____

☐ CORE V – Physician Assistant in Psychiatry (This box must be checked if you desire any of the privileges listed below)

This privileging section is only applicable to those applicants who have met Core I or II requirements for registration and certification and required experience and documentation in addition to the educational requirements listed below:

Privileges	Additional Educational Requirements	Required Documentation and Experience
Core V privileges for the Physician Assistant in Psychiatry include that which is outlined in the general Physician Assistant Core I or II privileges. The Psychiatry Physician Assistant provides care to adult patients on inpatient psychiatric units and occasionally in the outpatient clinic. Psychiatry Physician Assistants are privileged to perform face-to-face evaluations on patients in restraint/seclusion. The Psychiatry Physician Assistant must be proficient in performing mental health, chemical health, and medical evaluation. Knowledge of DSM IV diagnosis and the civil commitment process is essential.	Same as Core I or II.	**New Applicants**: Two (2) letters of reference from physicians or other practitioners, familiar with the applicant's current clinical competence. At least one (1) letter must be from another Physician Assistant. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____ Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Emal: _____ **Reappointment Applicants**: Evaluation of current competency conducted by a Physician Assistant of your choice. Please indicate name and address of the individual whom we may contact. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____

☐ CORE VI - Prescribing Authority for Physician Assistant (Check box for this privileges)

Privileges	Additional Educational Requirements	Required Documentation and Experience
Ability to dispense categories of drugs	1) Current registration to practice as Physician Assistant in Minnesota **and** 2) National certification by one of the certifying boards **and** 3) Current DEA Registration Certificate	**New Applicants**: 1) Physician Assistant - Physician Supervisory Agreement with Delegation of Prescriptive Practice section completed 2) Internal Protocol and Prescribing Delegation form. **Reappointment Applicants**: 1) Current Physician Assistant - Physician Supervisory Agreement with Delegation of Prescriptive Practice section completed 2) Current Internal Protocol and Prescribing Delegation form.

☐ **CORE VII – Physician Assistant Special Privileges (This box must be checked, in addition to checking the specific privileges, if you desire any of the privileges listed below). New graduates are eligible for 2 procedures only.**

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
☐ Chest Tube Insertion/Removal (Emergency Medicine or Surgery only) – new graduates – non eligible ☐ Central Line Insertion (Emergency Medicine only) new graduates – non eligible ☐ Endotracheal Intubation (Emergency Medicine only). New graduates – non eligible	Same as Core II.	**New Applicants**: Documentation of successful completion of a training course in advanced airway techniques **or** Reference letter from Physician Assistant Program Director who is able to confirm the applicant's competency to perform the procedure(s) requested. **Reappointment Applicants**: Evaluation of current competency conducted by another Physician Assistant of your choice. Please indicate name and address of the individual whom we may contact. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____
☐ Fracture Splinting (Emergency Medicine or Surgery or Orthopedics only) - new graduates - eligible ☐ Surgical Assistant (Surgery or Orthopedics only) – new graduates - eligible	Same as Core I or II.	**New Applicants**: Documentation of successful completion of a training course in the procedure(s) **or** Reference letter from Physician Assistant Program Director who is able to confirm the applicant's competency to perform the procedure(s) requested. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____ **Reappointment Applicants**: Evaluation of current competency conducted by another Physician Assistant of your choice. Please indicate name and address of the individual whom we may contact. Name:_____ Name of Facility:_____ Add:_____ Ph/Fax#:_____ Email: _____

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges will not proceed until which time that the information is received.

_____ _____

Signature Date

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

_____ _____

Sponsoring Physician's Name (PLEASE PRINT) Date

_____ _____

Sponsoring Physician's Signature Date

TO BE COMPLETED BY DIVISION/SECTION HEAD:

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

_____ _____

Regions Division/Section Head Signature Date

Regions Hospital
Allied Health Practitioner
Delineation of Privileges
Moderate Sedation

Privilege
☐ Administer and manage moderate sedation/analgesia, a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accomplished by light tactile stimulation. A patent airway is maintained and spontaneous ventilation is adequate. Cardiovascular function is always maintained.
Basic education and minimal formal training
1. PA-C, NP, CNS 2. Successful completion of advanced practice degree / certification 3. Current ACLS, PALS or ATLS certification
Required documentation and experience
NEW APPLICANTS: 1. Provide documentation of successful completion of an examination provided by the Regions medical staff services ***Or*** Document experience by providing one of the following: • Evidence of successful completion of a moderate sedation test with passing score from another hospital; • Governing board letter from another hospital indicating the applicant has moderate sedation privileges; • Letter from Medical Staff Office at another hospital indicating specifically that the practitioner has moderate sedation privileges and the date they were granted; • If a recent graduate, attestation of competency from program director. 2. Provide documentation of current ACLS, PALS or ATLS certification. **REAPPOINTMENT APPLICANTS:** 1. Provide documentation of performing moderate sedation for at least ten (10) patients within the past 24 months; ***Or*** Provide documentation from Division/Section Head that attests to ongoing current competence. 2. Provide documentation of current ACLS, PALS or ATLS certification.

TO BE COMPLETED BY APPLICANT: I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information being requested of me for the privileges I am applying for. I understand my application for privileges will not proceed until the information is received.

_____ _____

Signature Date

TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL: I have reviewed and/or discussed the privileges requested and find them to be commensurate with this applicant's training and experience. I recommend this application proceed.

_____ _____

Signature Date