

CORE I — Emergency medicine privileges for physician assistant

Privileges

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, and evaluate interim patient status and document in the medical record.

Assess, evaluate, diagnose, and initially treat patients of all ages who present to the ED with any symptom, illness, injury, or condition and provide services necessary to ameliorate minor illnesses or injuries; stabilize patients with major illnesses or injuries and assess all patients to determine if additional care is necessary. Privileges do not include long-term care of patients on an inpatient basis. Privileges do not include ability to admit or perform scheduled elective procedures with the exception of procedures performed during routine emergency room visits.

Basic education and minimal formal training

1. Graduate of an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (known as Commission on Accreditation of Allied Health Education Programs prior to January 2001)
2. Current ACLS, PALS, or ATLS certification.

Required documentation and experience

NEW APPLICANTS:

1. Provide copy of current ACLS, PALS or ATLS certification.
2. License to practice as a physician assistant issued by the Minnesota Board of Medicine.
3. Current (re)certification by the National Commission on Certification of Physician Assistants.
4. Physician—Physician Assistant Delegation Agreement and Notice of Intent to Practice
5. Provide contact information for (1) a physician assistant and (2) a physician whom the credentialing specialist may contact to provide an evaluation of your clinical competence to perform the privileges requested.

Name: _____

Name: _____

Name of Facility: _____

Name of Facility: _____

Address: _____

Address: _____

Phone: _____ Fax: _____

Phone: _____ Fax: _____

Email: _____

Email: _____

REAPPOINTMENT APPLICANTS:

1. Provide copy of current ACLS, PALS or ATLS certification.
2. Physician—Physician Assistant Delegation Agreement and Notice of Intent to Practice
3. Provide contact information for a physician whom the credentialing specialist may contact to provide an evaluation of your clinical competence to perform the privileges requested.

Name: _____

Name of Facility: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Prescribing authority for physician assistant

Privileges
Dispense and administer categories of drugs including controlled substances.
Basic education and minimal formal training
<ol style="list-style-type: none">1. License to practice as a physician assistant issued by the Minnesota Board of Medicine.2. Current certification/recertification by NCCPA.3. DEA registration
Required documentation and experience
NEW APPLICANTS <ol style="list-style-type: none">1. Physician--Physician Assistant Delegation Agreement with Delegation of Prescriptive Practice section completed2. Delegation Agreement and Notice of Intent to Practice
REAPPOINTMENT APPLICANTS <ol style="list-style-type: none">1. Physician--Physician Assistant Delegation Agreement with Delegation of Prescriptive Practice section completed2. Internal Protocol and Prescribing Delegation form.

Core Procedure List — PA Clinical Privileges in Emergency Medicine

To the applicant: Strike through those procedures you do not wish to request.

This list is a sampling of procedures included in the cores. This is not intended to be all-encompassing but rather reflective of the categories/types of procedures included in the core

1. Administer analgesia
2. Administer medications and perform other emergency treatment
3. Perform anoscopy
4. Apply, remove, and manage casts and splints
5. Apply, remove, and change dressings and bandages
6. Perform wound debridement, suturing, and general care for superficial wounds and minor superficial surgical procedures
7. Immobilize (spine, long bone, soft tissue)
8. Insert and remove nasogastric tubes
9. Insert Heimlich (small gauge) valve
10. Manage epistaxis
11. Ocular tonometry
12. Perform arterial puncture and blood gas sampling
13. Perform incision and drainage of superficial and complex abscesses
14. Perform interpretation of EKGs
15. Perform preliminary interpretations of simple plain X-ray films
16. Perform routine immunizations
17. Perform urinary bladder catheterization
18. Perform venous punctures for blood sampling, cultures, and IV catheterization
19. Reduce joint dislocations
20. Perform removal of foreign body
21. Splint extremity fractures
22. Trephination and removal of nail
23. Perform lumbar puncture
24. Perform arthrocentesis
25. Perform paracentesis

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which – by education training, current experience and demonstrated performance – I am qualified to perform and that I wish to exercise at Regions Hospital. I understand that:

- 1. In exercising any clinical privilege granted, I am governed by Regions Hospital and Regions Medical Staff policies and rules applicable generally and any applicable to the particular situation.

I agree to supply Regions Hospital Medical Staff Services (or designee) with all the information that has been requested of me for the privileges that I have applied for. I also understand that my application for privileges will not proceed until 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

DIVISION / SECTION HEAD RECOMMENDATION

I have reviewed and/or discussed the clinical privileges requested and supporting documentation for the above-named applicant and make the following recommendation/s:

- Recommend all requested privileges
- Recommend privileges with the following conditions/modifications
- Do not recommend the following requested privileges

Privilege	Condition / Modification / Explanation
1.	
2.	
3.	
4.	

Notes:

Regions Division/Section Head Signature Date

Regions Hospital
Allied Health Practitioner
Delineation of Privileges
Moderate Sedation

Privilege
<input type="checkbox"/> 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
<ol style="list-style-type: none"> 1. PA-C, NP, CNS 2. Successful completion of advanced practice degree / certification 3. Current ACLS, PALS or ATLS certification
Required documentation and experience
<p>NEW APPLICANTS:</p> <ol style="list-style-type: none"> 1. Complete moderate sedation test provided by Regions medical staff services with passing score; Or Document experience by providing one of the following: <ul style="list-style-type: none"> • Evidence of successful completion of a moderate sedation test from another hospital with passing score; • 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. <p>REAPPOINTMENT APPLICANTS:</p> <ol style="list-style-type: none"> 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



Physician Assistant
Practice Location Notification
(formerly Notice of Intent to Practice)
MINNESOTA BOARD OF MEDICAL PRACTICE
University Park Plaza • 2829 University Avenue SE, Suite 500
Minneapolis, Minnesota 55414-3246
612-617-2130 or www.bmp.state.mn.us
Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

Month	Day	Year

Instructions

This form must be completed and **mailed directly to the Board** within 30 business days of starting practice, changing practice location, or changing supervising physician. A Notification is required for each place of employment.

1. Incomplete Notifications will not be accepted. Type or print for clarity.
2. The address and phone number listed is public information.
3. Physicians may only delegate prescribing authority to the extent of their own authority. PAs should review the physician's license status by searching their Professional Profile on the Board's website.
4. Evidence of review of the Notification and Delegation Agreement must be provided to the Board on the annual renewal form to ensure current practice is reflected.

Identification

Physician Assistant's Name (first,middle,last): _____

Business Address: _____

City, State, Zip: _____

DEA# (if none, write "N/A" or "None"): _____

Phone: _____ Email: _____

Supervising Physician (first,middle,last): _____

Business Address: _____

City, State, Zip: _____

DEA # (if none, write "N/A" or "None"): _____

Phone: _____ Email: _____

Current Delegation Agreement is on file at the following location: _____

Date expected to commence practicing with this supervising physician: _____

Does this Notification replace a previous Notification?

____ Yes

____ No

Prescribing Privileges

Supervising physicians may delegate to physician assistants who meet the criteria in Minn. Stat. §147A.18, Subd. 1, the authority to prescribe, dispense and administer legend drugs, controlled substances, and medical devices. The supervising physician is responsible for determining if the PA is qualified and knowledgeable to prescribe the medications delegated. It is recommended the PA be provided with a list of medications for their use. The supervising physician may alter medications on the list at any time without Board approval as long as the physician understands and determines the PA is qualified and knowledgeable in the use of these medications. The physician is ultimately responsible for the prescriptive practice of the PA.

Expiration Date of NCCPA Certification (must be current in order to prescribe) _____

Delegated Prescribing Authority (check one)

____ No, this PA does not qualify under Chapter 147A and/or I do not wish to delegate such authority.

____ Not yet, this PA does not currently qualify under Chapter 147A. Once this PA is NCCPA certified and has a license, I wish to delegate prescribing, dispensing and administering privileges.

____ Yes, this PA qualifies under Chapter 147A and I wish him/her to have prescribing, dispensing, and administering privileges.

PRACTICE LOCATION			
Primary PA Practice Location (Required Field)			Phone#
Street Address	City	State	Zip
Other Practice Location			Phone#
Street Address	City	State	Zip
Other Practice Location			Phone#
Street Address	City	State	Zip
Other Practice Location			Phone#
Street Address	City	State	Zip
Other Practice Location			Phone#
Street Address	City	State	Zip
Other Practice Location			Phone#
Street Address	City	State	Zip
Other Practice Location			Phone#
Street Address	City	State	Zip
Other Practice Location			Phone#
Street Address	City	State	Zip

ATTACH A SEPARATE PAGE OR PAGES, IF NECESSARY

ATTEST	
A. Physician Assistant	
I hereby certify that I have reviewed and understand the current laws pertaining to physician assistants, fully understand my responsibilities and that I have a physician-physician assistant Delegation Agreement in force and on file at the practice site.	
PA Name (Printed) _____	PA Signature _____
License # _____	Date _____
B. Supervising Physician	
I hereby certify that I have reviewed and understand the current laws pertaining to physician assistants. I have reviewed and understand the physician-physician assistant Delegation Agreement between the physician assistant and myself. I have reviewed and agree to abide by the terms of the Practice Location Notification, Delegation Agreement, and applicable state laws and rules. I agree to provide adequate supervision and to accept full medical responsibility for medical care rendered by the physician assistant named above.	
Physician Name (Printed) _____	Physician Signature _____
License # _____	Date _____



Physician – Physician Assistant Delegation Agreement

(formerly Supervisory Agreement)

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE, Suite 500

Minneapolis, Minnesota 55414-3246

612-617-2130 or www.bmp.state.mn.us

Hearing Impaired-Minnesota Relay Service

Metro Area 297-5353

Outside Metro Area 1-800-627-3529

Month	Day	Year

Instructions

1. Complete all parts of the Delegation Agreement. For any part that does not apply, mark "N/A" for clarity of the PA's intended scope of practice. **Do not submit to the Board unless specifically requested.**
2. Supervising physicians must review and understand the current Minn. Stat. § 147A requirements regarding PA licensure, practice, supervision, and delegation of prescribing.
3. Supervising physicians may only delegate prescribing within their license authority and to a PA who is currently NCCPA certified.
4. The Delegation Agreement must be kept on file at the practice site and reviewed at least annually at PA license renewal time.

Identification

Physician Assistant's Name (first,middle,last) _____

Signature _____ License # _____ Specialty _____

Supervising Physician (first,middle,last) _____

Signature _____ License # _____ Specialty _____

Physician Supervision

Minn. Stat. § 147A.01, Subd. 23 defines **Supervising physician** as "a Minnesota licensed physician who accepts full medical responsibility for the performance, practice, and activities of a physician assistant under agreement as described in § 147A.20. Minn. Stat. § 147A.01, Subd. 24 defines **Supervision** as "overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required so long as the supervising physician and physician assistant are or can be easily in contact with one another by radio, telephone, or other telecommunication device. The scope and nature of the supervision shall be defined by the individual physician-physician assistant delegation agreement."

Manner by which supervision will be accomplished. (A narrative description is acceptable).

Review of services provided by the physician assistant shall be accomplished by (choose one or more):

On site review Telecommunication Other:

Annual Delegation Agreement Review

Supervising Physician Initials _____	Date _____	Supervising Physician Initials _____	Date _____
Physician Assistant Initials _____	Date _____	Physician Assistant Initials _____	Date _____
Supervising Physician Initials _____	Date _____	Supervising Physician Initials _____	Date _____
Physician Assistant Initials _____	Date _____	Physician Assistant Initials _____	Date _____

Practice Sites

Practice locations are specified on the Practice Location Notification (PLN), which is submitted to the Board. A copy of the PLN should be kept at the practice site.

Delegation of Medical Services

As stated in Minn. Stat. § 147A.09, Subd. 1, physician assistants shall practice medicine only with physician supervision. Physician assistants may perform those duties and responsibilities as delegated in the physician-physician assistant Delegation Agreement maintained at the address of record by the supervising physician and physician assistant, including the prescribing, administering, and dispensing of medical devices and drugs, excluding anesthetics, other than local anesthetics, injected in connection with an operating room procedure, inhaled anesthesia and spinal anesthesia.

Patient services must be limited to services within the training or experience of the physician assistant, services customary to the practice of the supervising physician, services delegated by the supervising physician, and services within the parameters of the laws, rules and standards of the facilities in which the physician assistant practices.

Orders of physician assistants shall be considered the orders of their supervising physicians in all practice-related activities, including, but not limited to, the ordering of diagnostic, therapeutic, and other medical services.

The supervising physician should indicate below the patient services s/he chooses to delegate to the physician assistant. Indicate "yes" for those delegated or "no" for each item. Attach a separate sheet, if necessary, and cite this below.

- No Yes 1. Take patient histories and develop medical status reports
- No Yes 2. Perform physical examinations
- No Yes 3. Interpret and evaluate patient data
- No Yes 4. Order or perform diagnostic procedures
- No Yes 5. Order or perform therapeutic procedures
- No Yes 6. Provide instructions regarding patient care, disease prevention, and health promotion
- No Yes 7. Assist the supervising physician in patient care in the home and in health care facilities
- No Yes 8. Create and maintain appropriate patient records
- No Yes 9. Transmit or execute specific orders at the direction of the supervising physician
- No Yes 10. Prescribe, administer, and dispense drugs, controlled substances and medical devices in accordance with section 147.18 and chapter 151 per Delegation Agreement.
- No Yes 11. For physician assistants not delegated prescribing authority, administering legend drugs and medical devices following prospective review for each patient by and upon direction of the supervising physician.
- No Yes 12. Function as an emergency medical technician with permission of the ambulance service and in compliance with section 144E.127 and ambulance service rules adopted by the Emergency Medical Services Regulatory Board.
- No Yes 13. Initiate evaluation and treatment procedures essential to providing an appropriate response to emergency situations.
- No Yes 14. Perform and sign the documentation for Department of Transportation exams
- No Yes 15. Perform and sign the documentation for school bus driver exams
- No Yes 16. Request diagnostic or therapeutic radiologic procedures (including but not limited to x-rays, CT scans, MRI scans, ultrasound, nuclear imaging studies)
- No Yes 17. Certify a patient's eligibility for a disability parking certificate under section 169.345, subdivision 2
- No Yes 18. Assist in surgery
- No Yes 19. Provide medical authorization for the immediate detention on a 72 hour hold for a patient in danger of causing injury to self or others in accordance with 253B.05, subdivision 2
- No Yes 20. Order or perform diagnostic procedures, including the use of radiographic imaging systems in accordance with Minnesota Rules 2007, Chapter 4732;
- No Yes 21. Order or perform therapeutic procedures with the use of ionizing radiation in accordance with Minnesota Rules 2007, Chapter 4732;
- No Yes 22. Other (please specify) _____
- see addendum dated:

Delegation of Prescriptive Practice

Supervising physicians may delegate to physician assistants who meet the criteria in Minn. Stat. § 147A.18, Subd. 1, the authority to prescribe, dispense and administer legend drugs, controlled substances, and medical devices. The supervising physician is responsible for determining if the PA is qualified and knowledgeable to prescribe the medications delegated. The supervising physician may alter medications at any time by updating the Delegation Agreement without Board approval as long as the physician understands and determines the PA is qualified and knowledgeable in the use of these medications. The physician is ultimately responsible for the prescriptive practice of the PA.

The supervising physician hereby delegates the following prescriptive practice to the physician assistant (choose one)

- No prescriptive practice (go to page 4)
- This PA may prescribe, dispense, or administer as indicated below:

A. Medication Categories. Exceptions may be listed for any category at right.

- No Yes 01 Anesthetics (note Minn. Stat. §147A.09, Subd.1)
- No Yes 02 Antiinfectives.....
- No Yes 03 Antineoplastics & Immunosuppressants
- No Yes 04 Cardiovascular Medications.....
- No Yes 05 Autonomic & Central Nervous System Drugs
- No Yes 06 Dermatological Drugs
- No Yes 07 Diagnostic Agents
- No Yes 08 Ear – Nose - Throat Medications
- No Yes 09 Endocrine Medications
- No Yes 10 Gastrointestinal Medications.....
- No Yes 11 Immunologicals & Vaccines
- No Yes 12 Musculoskeletal Medications
- No Yes 13 Nutritional Products, Blood Modifiers & Electrolytes
- No Yes 14 Obstetrical & Gynecological Medications
- No Yes 15 Ophthalmic Medications
- No Yes 16 Respiratory Medications
- No Yes 17 Urological Medications.....

B. Controlled Substances

- No Yes 18 schedule V
- No Yes 19 schedule IV
- No Yes 20 schedule III
- No Yes 21 schedule II

C. Medical Devices

- No Yes 22

Review of Delegated Prescribing

Minn. Stat. § 147A.18 Subd. 1.(b) states: "Supervising physicians shall retrospectively review the prescribing, dispensing, and administering of legend and controlled drugs and medical devices by physician assistants, when this authority has been delegated to the physician assistant as part of the delegation agreement between the physician and the physician assistant. The process and schedule for the review must be outlined in the physician-physician assistant delegation agreement."

Indicate the process for review of delegated prescribing. (choose all that apply, or provide a narrative if desired).

- Review a representative sample of patient care notes.
- Audit of medical records.
- Case discussion between supervising physician and physician assistant.
- Other: _____

Indicate the schedule for review. (choose one)

- daily weekly monthly quarterly other (specify): _____

ATTEST

A. Physician Assistant

I hereby certify that I have reviewed and understand the current laws pertaining to physician assistants and fully understand my responsibilities and that I must have this physician-physician assistant Delegation Agreement in force and on file at the practice site.

PA Name (Printed) _____ PA Signature _____

License # _____ Date _____

B. Supervising Physician

I hereby certify that I have reviewed and understand the current laws pertaining to physician assistants. I have reviewed and understand the physician-physician assistant Delegation Agreement between the physician assistant and myself. I have reviewed and agree to abide by the terms of the Practice Location Notification, Delegation Agreement, and applicable state laws and rules. I agree to provide adequate supervision and to accept full medical responsibility for medical care rendered by the physician assistant named above.

Physician Name (Printed) _____ Physician Signature _____

License # _____ Date _____