OTOLARYNGOLOGY PHYSICIAN ASSISTANT CLINICAL PRIVILEGES

Notice to Applicant: Applicants have the burden of producing information deemed adequate by University of Mississippi Medical Center (UMMC) for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

- Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff and other support required to provide the services defined in this document. Site-specific services may be defined in hospital and/or department policy.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional governance (Medical Staff Bylaws, Rules and Regulations) organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR PHYSICIAN ASSISTANT

To be eligible to apply for core privileges as a Physician Assistant, the initial applicant must meet the following criteria:

- Education: Master's degree or higher in Physician Assistant Studies or equivalent area of study
- Training: Successful completion of an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) (or one of its predecessors) accredited Physician Assistant education program
- Board Certification:
    - Current certification by the National Commission on Certification of Physician Assistants (NCCPA); or
    - Currently in the process to achieve board certification, in which case the physician assistant must become certified by the NCCPA within six (6) months of completion of formal training
- Required Previous Experience:
    - Initial appointment:
        - Demonstration of the provision of care, reflective of the scope of privileges requested, for a sufficient volume of adult and/or pediatric inpatients or outpatients during the past 24 months; or
        - Successful completion of an ARC-PA accredited program within the past 12 months.
    - Reappointment:
        - Current demonstrated competence and a sufficient volume of experience in adult and/or pediatric inpatients or outpatients, with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Provider Name: _____

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	Otolaryngology Physician Assistant Core Privileges and Procedures **DO NOT request privileges you will not be performing in your current role.**
Check requested privileges below	***Please strike through and initial any privilege you wish to exclude from those listed below.***
☐	Assess, evaluate, diagnose, treat and provide consultation to patients of all ages who present with any symptom, illness, injury or condition and provide services necessary to ameliorate minor illnesses and/or injuries (in conjunction with supervising physician). Stabilize patients with major illnesses or injuries and assess all patients to determine if additional care is necessary. Order and interpret appropriate diagnostic tests. Perform evaluations. Order appropriate referrals and consultations. Initiate, change or discontinue medical treatment plan. Prescribe, initiate, and monitor all medications which PAs are authorized to prescribe in Mississippi. Initiate consultation for and monitor patients during special tests. The core privileges in this specialty include the procedures listed below. • Aspiration of superficial abscess or cyst • Control of epistaxis • Cryosurgery/cautery for benign disease • Emergent endotracheal intubation • Emergent ventilator management • Fiber optic endoscopic evaluation of swallowing (FEES) • Flexible laryngoscopy • I & D abscess • Insertion and removal of IVs • Insertion of indwelling urinary catheters • Local anesthetic techniques • Lumbar puncture • Myringotomy with or without tympanostomy tube placement • Nasogastric tube insertion/removal • Order rehab services • Order respiratory services • Paracentesis • Perform electrocardiogram tracing • Perform history and physical exam • Perform simple skin biopsy or excision • Perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods • Peripheral nerve blocks • Phlebotomy • Placement of anterior and posterior nasal hemostatic packing • Pre and post-operative management of surgical patients • Remove non-penetrating foreign body from the eye, nose, or ear • Scar revision • Sialolithotomy • Skin biopsy • Suture uncomplicated lacerations • Telehealth • Video stroboscopy • Wound care (including cleansing and debridement)

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	Non-Core Privileges and Procedures DO NOT request privileges you will not be performing in your current role.	
Check requested privileges below		
☐	**Administration of Sedation and Analgesia**	Successful completion of Healthstream module: "Procedural Sedation Credentialing"
☐	**First Assist in Surgery**	*Criteria*: • Successful completion of formal training in this procedure or the applicant must have completed hands-on training in this procedure under the supervision of a qualified physician preceptor. *Required Previous Experience*: • Demonstrated current competence and evidence of the performance of a sufficient volume of procedures in the past 24 months or completion of a preceptorship within the past 12 months consisting of at least 5 precepted procedures. *Maintenance of Privilege*: • Demonstrated current competence and evidence of the performance of a sufficient volume of procedures in the past 24 months based on results of quality assessment/improvement activities and outcomes.

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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 for which I wish to exercise at University of Mississippi Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed_____ ***Date***_____

PHYSICIAN SUPERVISOR'S RECOMMENDATION:
I have reviewed and recommend the above requested privileges based on the provider's training and/or background.

_____ _____
Signature of Physician Supervisor Date

DIVISION CHIEF'S RECOMMENDATION (IF APPLICABLE):
I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I 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

_____
_____
_____

Division Chief Signature_____ ***Date***_____

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DEPARTMENT CHAIR'S RECOMMENDATION (IF APPLICABLE):

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I 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

_____
_____
_____

Department Chair Signature_____ ***Date***_____

Reviewed (without revision):

Revised:

Provider Name: _____