

UNIVERSITY HOSPITAL AND HEALTH SYSTEM
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 North State Street, Jackson MS 39216

CLINICAL PRIVILEGES- WOMEN'S HEALTH NURSE PRACTITIONER

Name: _____

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- ☐ Initial Appointment
☐ Reappointment

Department _____
Specialty _____

All new applicants must meet the following requirements as approved by the governing body effective: March 4, 2015.

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Department Chair: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

- 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 (MS Bylaws, Rules and Regulations) organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR WOMEN'S HEALTH NURSE PRACTITIONER

To be eligible to apply for core privileges as a Women's Health Nurse Practitioner, the initial applicant must meet the following criteria:

Current certification as a Women's Health Nurse Practitioner by the American Nurses Credentialing Center (ANCC), American Academy of Nurse Practitioners (AANP), or an equivalent body as required by licensure;

Required Previous Experience: Applicants for initial appointment must be able to demonstrate clinical experience as a Women's Health Nurse Practitioner during the past 24 months or demonstrate successful completion of an accredited Women's Health Nurse Practitioner program within the past 12 months.

Reappointment Requirements: To be eligible to renew core privileges as a Women's Health Nurse Practitioner, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience, (inpatients, outpatients, or consultations) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

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CORE PRIVILEGES

WOMEN'S HEALTH NURSE PRACTITIONER CORE PRIVILEGES

☐ **Requested**

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 collaborating physician). Stabilize patients with major illnesses or injuries and to assess all patients to determine if additional care is necessary. Order and interpret appropriate diagnostic tests. Perform evaluations. Order appropriate referrals and consultations. Change or discontinue medical treatment plan. Prescribe, initiate, and monitor all medications which APRNs are authorized to prescribe in Mississippi. Initiate consultation for and monitor patients during special tests.

The core privileges include the procedures on the attached procedure list.

ADMINISTRATION OF SEDATION AND ANALGESIA

- ☐ **Requested** See Hospital Policy for Procedural Sedation by Non-Anesthesiologists for additional information.

Section One--INITIAL REQUESTS ONLY:

- ☐ Demonstration of prior clinical privileges to perform procedural sedation along with a good-faith estimate of at least 20 such sedations performed during the previous year (the estimate should include information about each type of procedure where sedation was administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:
- _____

-OR-

- ☐ Successful completion (within six months of application for privileges) of a UMHC-approved procedural sedation training and examination course that includes practical training and examination under simulation conditions.

Section Two--INITIAL AND RE-PRIVILEGING REQUESTS:

- ☐ Successful completion of the UMHC web based Procedural Sedation Course/Exam initially and at least once every two years **-AND-**

Provision of a good-faith estimate of the number of instances of each type of procedure where sedation is administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:

-AND-

- ☐ ACLS, PALS and/or NRP, as appropriate to the patient population. **(Current)**

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Section Three--INITIAL AND RE-PRIVILEGING REQUESTS:

- ☐ Controlled Substance Prescriptive Authority Schedules II – V approval from the Mississippi Board of Nursing.

PRESCRIPTIVE AUTHORITY

____ I have been approved for the following schedules by the Mississippi State Board of Nursing and have attached a copy of my approved Controlled Substance Prescriptive Authority registration.
____ II ____ III ____ IV ____ V

____ I do not have Controlled Substance Prescriptive Authority in Mississippi.

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CORE PROCEDURE LIST

To the applicant: If you wish to exclude any procedures, please strike through those procedures which you do not wish to request, initial, and date. ***Procedures that are not in concert with your collaborating physician's privileges should be stricken from this list.***

- Abcess incision and drainage, including Bartholin' s cyst
- Anesthetic nerve blocks- local, regional, digital and dental
- Arterial puncture
- Bladder decompression and catheterization techniques
- Blood component transfusion therapy
- Debridement
- Preliminary EKG interpretation
- Epistaxis, management of
- Histories and physicals, performance of
- Laceration repair
- Oxygen therapy
- Perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods
- Preliminary evaluation of radiological studies(plain radiographs, CT, MRI scans)
- Rehab service ordering
- Respiratory services, ordering of
- Restraints, Chemical and/or physical of agitated patient in accordance with hospital policy
- Routine immunizations, performance of
- Routine screening tests such as pap smears, pregnancy tests, Chlamydia testing, wet preps, gonorrhea cultures, hemoglobin test, and microscopic urinalysis
- Suprapubic catheter reinsertion

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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 Hospital and Health System, 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** _____

DIVISION CHIEF'S RECOMMENDATION (AS 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

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:

Revised: 4.1.15