Kaleida Health

DEPARTMENT OF FAMILY MEDICINE
NURSE PRACTITIONER

ADVANCED PRIVILEGES

_____
Name of Nurse Practitioner (Print)

To be eligible to apply for privileges as a Nurse Practitioner in Family Medicine, the applicant must currently possess Nurse Practitioner Core Privileges as a member of the Kaleida Health Medical/Dental Staff.

FAMILY MEDICINE NURSE PRACTITIONER CORE PRIVILEGES

Provide care, treatment, and services consistent with family medicine practice, including the performance of physical exams, diagnosing conditions, the development of treatment plans, health counseling, and prescribing medications in accordance with New York State law for patients within the age group of patients seen by the collaborating physician. Nurse practitioners may write orders that include ongoing orders, discharge orders and admission orders under the physician's service to the hospital. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the Nurse Practitioner Core Privileges and such other procedures that are extensions of the same techniques and skills.

ADVANCED PRIVILEGES (see specific criteria)

Noncore privileges are requested individually in addition to requesting the core. Each individual requesting advanced privileges must meet the specific threshold criteria as applicable to the initial applicant or reapplicant. Each time a new privilege is requested, it may be requested by the Nurse Practitioner and recommended by the collaborating physician and forwarded to the Kaleida Health Medical Staff Office to be approved and appended to the advanced list of privileges.

Advanced Privileges – The applicant must provide written documentation of current competence (as noted below) for all procedures requested:

1. A list of requested procedures performed within the educational program, signed by a representative of the program, attesting to competence **OR** a case list of requested procedures performed within the previous 2 years **OR**
2. A signed statement from the collaborating physician confirming that he/she has personally observed the applicant successfully perform the procedure(s) and can attest to his/her competence.

If the above requirements cannot be met, the applicant may request approval to perform the procedure(s) under direct supervision until such time as the above noted attestation can be submitted. This request must be co-signed by the collaborating physician.

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_____
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Advanced Privileges continued…	**Requested**		**Approved**	***Not Approved**	**With Direct Supervision**
Joint Injections					
Reinsertion of an established gastrostomy tube or jejunostomy tube (Foley catheter type only)					
Reinsertion of an established suprapubic catheter					
Wound Debridement					

To be completed for reappointment only:

I attest that I have reviewed the Practice Agreement previously submitted.
(check one of the following)

____ No revisions are necessary; the agreement reflects current practices and protocols.
____ Revisions have been made and an updated copy is attached.

THE COLLABORATING PHYSICIAN MUST COMPLETE THIS SECTION by checking one of the following:

_____ a) I, as collaborating physician, have personally observed _____ (applicant's name) in the clinical setting and can attest he/she has the cognitive skills appropriate.

_____ b) I, as collaborating physician, **have not** personally observed _____ (applicant's name) in the clinical setting and recommend he/she be given a six (6) month provisional approval with direct supervision at the end of which an attestation as to competence will be required.

_____ c) I, as collaborating physician, **have not** personally observed _____ (applicant's name) in the clinical setting but will waive the six (6) month provisional approval period based on commensurate experience.

_____	_____	_____
Practitioner's Name (Print)	Practitioner's Signature	Date
_____	_____	_____
Collaborating Physician's Name (Print)	Collaborating Physician's Signature	Date
_____		_____
Chief of Service Signature		Date
_____		_____
Advanced Practice Provider Committee		Date