

CRITERIA FOR GRANTING EMERGENCY ROOM PHYSICIAN PRIVILEGES

The following are minimum requirements for emergency physicians:

1. Ability to evaluate and treat common emergencies in all sexes and age groups, including pediatric and geriatric patients.
2. Board Certified or ACLS Certification (EKG Interpretation, arrhythmia management, MI management, IV management).
3. Ability to manage shock (cardiogenic, fluid loss, septic, traumatic).
4. Ability to treat poison (overdose) victims, including N.G. tube insertion.
5. Ability to perform thoracentesis, pericardiocentesis, paracentesis, tube thoracostomy.
6. Ability to manage airway problems including cricothyroidotomy/intubation.
7. Ability to deliver an uncomplicated term pregnancy.
8. Initial management of infectious and metabolic disorders.
9. Minor trauma management (lacerations, burns, foreign bodies)
10. Major trauma, initial evaluation and stabilization.
11. Initial management of emergency conditions including history, physical examination and ordering and interpretation of basic laboratory, radiology, cardiology and pulmonary studies.
12. Conduct medical screening exam for EMTALA

FOR EVALUATION OF ALL PATIENTS PRESENTED IN EMERGENCY ROOM

<u>PRIVILEGES REQUESTED</u>	<u>APPROX. # PERFORMED LAST 2 YEARS</u>	<u>APPROVED AND/OR COMMENTS</u>
_____ ABSCESSES AND HEMATOMAS - INCISION AND DRAINAGE	_____	_____
_____ BURNS	_____	_____
_____ CATHETERS - PLACING INTO THE URINARY BLADDER	_____	_____
_____ DENTAL PROBLEMS - ACUTE	_____	_____
_____ FOREIGN BODIES - REMOVAL OF SUPER- FICIAL EYE, EAR, NOSE, VAGINA AND RECTUM	_____	_____
_____ FRACTURES/DISLOCATIONS, INITIAL STABILIZATION	_____	_____

Foothill Presbyterian Hospital
 Emergency Services Privileges Request Form
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<input type="checkbox"/> INTRAVENOUS CATHETER	_____	_____
<input type="checkbox"/> LACERATIONS - REPAIR	_____	_____
<input type="checkbox"/> LUMBAR PUNCTURE	_____	_____

<u>PRIVILEGES REQUESTED</u>	<u>APPROX. # PERFORMED LAST 2 YEARS</u>	<u>APPROVED AND/OR COMMENTS</u>
<input type="checkbox"/> NASAL PACKS	_____	_____
<input type="checkbox"/> POISONOUS STINGS AND BITES	_____	_____
<input type="checkbox"/> PROCTOSCOPY	_____	_____
<input type="checkbox"/> PSYCHIATRIC EVALUATION	_____	_____
<input type="checkbox"/> RADIOGRAPHIC STUDIES	_____	_____

**ANESTHESIA:
 PRIVILEGES REQUESTED:**

<input type="checkbox"/> LOCAL ANESTHESIA	_____	_____
<input type="checkbox"/> REGIONAL BLOCK ANESTHESIA	_____	_____
<input type="checkbox"/> CONSCIOUS SEDATION	_____	_____

OTHER:

On the basis of my training and experience, I am qualified to exercise and request the privileges which I have checked.

I have not requested privileges for any procedures for which I am not qualified. I am familiar with the laws of the State governing the practice of medicine and pledge to abide by these laws.

PRIVILEGES APPROVED: [] AS REQUESTED [] AS MODIFIED BELOW

 Physician's Signature

 Date

 Chair, Medical Department

 Date