SRMC Nurse Practitioner (CNP) Radiology
Special Non-core Procedures (Appendix P)

Name: _____________________________________

Effective Dates: _________ To: __________

☐ Initial privileges (initial appointment)

☐ Renewal of privileges (reappointment)

☐ Expansion of privileges (modification)

All new applicants must meet the following requirements as approved by the SRMC Board effective: 08/26/2015

INSTRUCTIONS

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.

Clinical Service Chief/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

1. Note that privileges granted may only be exercised at SRMC 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 or department policy.

2. This document defines qualifications to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.
Special Procedures in Radiology

**Criteria:** Currently privileged with core privileges as a CNP at SRMC. Successful completion of training in requested procedure(s), or documentation of a special course for requested procedure(s) accompanied with demonstrated proctoring for requested procedures with acceptable outcomes.

**Required Current Experience:** Demonstrated current competence and evidence of performance of an acceptable volume of requested procedure(s) with acceptable results in the past 12 months.

**Renewal of Privilege:** Demonstrated current competence and evidence of performance of an acceptable volume of requested procedure(s) with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

**Qualifications for Arterial Access**

**Criteria:** Demonstrated current competence with evidence of training and supervised arterial access for at least 3 procedures.

**Renewal of Privilege:** Demonstrated current competence and evidence of performance of an acceptable volume of requested procedure(s) with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

**NON-CORE PRIVILEGE: Arterial Access**

☐ Requested

**Qualifications for Central Line Placement**

**Criteria:** Demonstrated current competence with evidence of training and supervised placements of at least 10 placements for each of the specific site requested with acceptable outcomes.

**Renewal of Privilege:** Demonstrated current competence and evidence of performance of an acceptable volume of requested procedure(s) with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

**NON-CORE PRIVILEGE: Central Line Placement**

☐ Requested
Name: _____________________________________

Qualifications for Drainage tube exchange/management

*Criteria:* Demonstrated current competence with evidence of training and at least 5 supervised exchanges for each drain location with acceptable outcomes.

*Renewal of Privilege:* Demonstrated current competence and evidence of performance of an acceptable volume of drain tube placements with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

**NON-CORE PRIVILEGE:** Drainage tube exchange/management

☐ Requested

Qualifications for Fluoroscopy

*Criteria:* Demonstrated current competence with evidence of training and supervision of at least 10 fluoroscopic procedures specific to the procedure requested with acceptable outcomes.

*Renewal of Privilege:* Demonstrated current competence and evidence of performance of an acceptable volume of requested procedure(s) with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

**NON-CORE PRIVILEGE:** Fluoroscopy (under general supervision)

☐ Requested

Qualifications for Fluoroscopic vascular imaging (venography only)

*Criteria:* Demonstrated current competence with evidence of training and supervision of at least 5 fluoroscopic vascular imaging procedures.

*Renewal of Privilege:* Demonstrated current competence and evidence of performance of an acceptable volume of requested procedure(s) with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

**NON-CORE PRIVILEGE:** Fluoroscopic vascular imaging - venography only (under general supervision)

☐ Requested
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Name: _____________________________________

Qualifications for Paracentesis

Criteria: Demonstrated current competence with evidence of training and supervision of at least 5 paracentesis procedures with acceptable outcomes.

Renewal of Privilege: Demonstrated current competence and evidence of performance of an acceptable volume of paracentesis procedures with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☑ Requested

Non-core Privilege: Paracentesis

Qualifications for Thoracentesis

Criteria: Demonstrated current competence with evidence of training and supervision of at least 5 thoracentesis procedures with acceptable outcomes.

Renewal of Privilege: Demonstrated current competence and evidence of performance of an acceptable volume of thoracentesis procedures with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☑ Requested

Non-core Privilege: Thoracentesis
Qualifications for Ultrasound as adjunct to privileged procedure

Criteria: Demonstrated current competence with evidence of training and supervision of at least 5 ultrasound procedures specific to the procedure requested with acceptable outcomes.

Renewal of Privilege: Demonstrated current competence and evidence of performance of an acceptable volume of ultrasound procedures with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

NON-CORE PRIVILEGE: Ultrasound as adjunct to privileged procedure

1. Central Line Placement
2. Drainage tube exchange/management
3. Fluid collection evaluation
4. Paracentesis
5. Thoracentesis

☐ Requested
SRMC Nurse Practitioner (CNP) Radiology
Special Non-core Procedures (Appendix P)

Name: ________________________________

Acknowledgment 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 SRMC, 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 ____________________

Clinical Service Chief

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

☐ Recommend all requested privileges with the standard professional practice plan
☐ Recommend privileges with the standard professional practice plan and the following conditions/modifications:________________________________________________________
☐ Do not recommend the following requested privileges:

Privilege Condition/Modification/Explanation Notes:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Clinical Service Chief Signature ________________________ Date ____________________

Approved by SRMC Board: 08/26/2015
Version 1