UNMH Nurse Practitioner & Physician Assistant (CNP & PA)
Orthopedics Special Procedures (Appendix M)

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 UNMH Board of Trustees effective: 07/25/2014

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.

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 UNM Hospitals and clinics 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.

Name:
Effective Dates: ____________ To: ____________

Qualifications for Special Procedures in Orthopedics

Criteria: Currently privileged with core privileges as a CNP or PA at UNM Hospitals and clinics. 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.

NON-CORE PRIVILEGE: *Closed reductions of fractures and dislocations*

☐ **Requested**

NON-CORE PRIVILEGE: *Splinting and Casting*

☐ **Requested**

NON-CORE PRIVILEGE: *Surgical First Assist under direct supervision (except as specified)*

1. Including unsupervised skin closure

☐ **Requested**

Qualifications for Nerve Blocks

Criteria: Demonstrated current competence with evidence of training and supervision of at least 5 nerve blocks 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: *Nerve Blocks - peripheral (single injection)*

1. Digital

☐ **Requested**

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____

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 UNM Hospitals and clinics, 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 Director/Division Chief recommendation(s) *(if applicable)*

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

Name_______________________ Signed ______________________ Date ___________________

Name_______________________ Signed ______________________ Date ___________________

Department Chair recommendation

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:

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Department Chair Signature _______________________________ Date _____________________

Criteria approved by UNMH Board of Trustees on 07/25/2014