

LEHIGH VALLEY HEALTH NETWORK
CLINICAL PRIVILEGES IN AHP - LPN - OBSTETRICS AND GYNECOLOGY

Initial Renewed

Effective from ___/___/___ to ___/___/___

Name _____

R = Requested G = Recommended As Requested C = Recommended with Conditions N = Not Recommended

R G C N POPULATION

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pediatric: Birth - 25 Years (Fairgrounds Surgical Center, LVHN Surgery Center-Tilghman, and LVHN Children's Surgery Center - 6 months - 18 Years) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adults: 13 - 65 Years |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Geriatrics: Over 65 years |

R G C N PRIVILEGES WITH SUPERVISION (b)

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Accompany doctors on patient rounds (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Act as liaison to collect information from patient and family in regard to insurance coverage (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assist with patient discharge procedures (1,2,3,4) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Provide and document patient instructions as needed, especially in regard to post-partum teaching (1,2,3,4) |

LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

CLINICAL PRIVILEGES IN AHP - LPN - OBSTETRICS AND GYNECOLOGY

Name _____

Qualifications:

Will function in joint collaboration with the physician or physician group with which she/he is associated.

SITES OF PRIVILEGE

- 1 – LVH-Cedar Crest
- 2 – LVH-Muhlenberg (includes the Behavioral Health Center and Cancer Center)
- 3 – LVH-17th & Chew (includes TSU)
- 4 – Fairgrounds Surgical Center
- 5 – LVH-Tilghman
- 6 – LVHN Surgery Center-Tilghman
- 7 – LVH-Hazleton
- 8 – Health and Wellness Center at Hazleton
- 9- LVHN Children's Surgery Center
- 10 - LVH-Schuylkill East Norwegian
- 11 - LVH-Schuylkill South Jackson
- 12 - LVH-Schuylkill Surgery Center

DEFINITIONS OF SUPERVISION

(a) DIRECT SUPERVISION - The physical presence of the supervising physician on the premises so that the supervising physician is immediately available to the allied health professional when needed.

(b) SUPERVISION - The control and personal direction exercised by the supervising physician over the medical services provided by an allied health professional. Constant physical presence of the supervising physician is not required so long as the supervising physician and the allied health professional are, or can easily be, in contact with each other by radio, telephone or telecommunications. Supervision requires the availability of the supervising physician to the allied health professional.

(c) SUPERVISING PHYSICIAN IN ATTENDANCE - Physical presence of supervising physician in room.

* ATTENTION SUPERVISING PHYSICIAN: Your signature, title and date are required on the first line of the signature page of this document.

LEHIGH VALLEY HEALTH NETWORK

CLINICAL AREA AHP - LPN - OBSTETRICS AND GYNECOLOGY

Name _____

Acknowledgement of Practitioner

I hereby request the privileges noted.

Practitioner Signature: _____ Date: ____/____/____

Recommendations

I have reviewed the request for clinical privileges and supporting documentation and

Recommend As Requested **Recommend with Exceptions** **Do Not Recommend**
the privileges requested above.

EXCEPTIONS

Exception to Privilege:	Conditions/Modifications

Explanation:

SUPERVISING PHYSICIAN (AHPs ONLY)

Title	Signature _____	Date ____/____/____
Title	Signature _____	Date ____/____/____
Title	Signature _____	Date ____/____/____
Title	Signature _____	Date ____/____/____
Title	Signature _____	Date ____/____/____

