OB/GYN – WOMEN’S HEALTH

PHYSICIAN ASSISTANT

ADVANCED PRIVILEGES

Name of Physician Assistant (Print)

To be eligible to apply for privileges as a Physician Assistant in OB/GYN Women’s Health practice, the applicant must currently possess Physician Assistant Core Privileges as a member of the Kaleida Health Medical/Dental Staff.

OB/GYN WOMEN’S HEALTH PHYSICIAN ASSISTANT CORE PRIVILEGES

Provide care, treatment, and services consistent with women’s health OB/GYN practice including the performance of physical exams, diagnosing conditions, the development of treatment plans, health counseling, prescribing medications in accordance with New York State law, and assisting in surgery for patients within the age group of patients seen by the Supervising physician. Includes: cryosurgery (for removal of benign lesions), debridement and general care for superficial wounds and minor superficial surgical procedures, performing incision and drainage of superficial abscesses, removal of skin clips or sutures, pregnancy testing and care before, during, and after pregnancy, evaluation and treatment of common vaginal infections, screening and referral for other health problems, including suspected sexual abuse and rape, screening for high-risk pregnancies, pregnancy complications, and postpartum complications, STD screening and follow-up. Physician Assistants may write orders that include ongoing orders, discharge orders and admission orders under the physician’s service to the hospital. May 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 Physician Assistant Core Privileges and such other procedures that are extensions of the same techniques and skills.

PRACTICE RELATIONSHIPS (excerpted from Article 131-B Section 6542 of the NYS Education Law)

Physician assistants act solely on delegation from the supervising physician. The physician assistant is entitled to use his/her medical skills and knowledge in the performance of medical acts, functions, and services only on delegation from, and on behalf of the supervising physician. It is the responsibility of the supervising physician to assure that the physician assistant is competent to perform that which is delegated.

The New York State Education Law and related regulations provide that Physician Assistants may perform medical services only under the supervision of a physician. Supervision shall be continuous, but shall not necessarily require the physical presence of the physician at the time and place the services are provided. A physician may not supervise more than two physician assistants in a private practice or more than six physician assistants in the hospital setting.

The statute and implementing rules and regulations provide that medical acts, functions, and services delegated to the physician assistant must be within the scope of practice of the supervising physician and must be appropriate to the education, training, and experience of the physician assistant to whom they are assigned. The scope of practice within a hospital setting is at the discretion of the hospital Board of Directors.

OB/GYN Women’s Health PA SOP 6/2019
DEPARTMENT OF OB/GYN-WOMEN’S HEALTH
PHYSICIAN ASSISTANT

ADVANCED PRIVILEGES

Name of Physician Assistant (Print)

ADVANCED PRIVILEGES (see specific criteria)

Non-core 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 re-applicant. Each time a new privilege is requested, it may be requested by the Physician Assistant and recommended by the Supervising 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 Supervising 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 Supervising physician.

<table>
<thead>
<tr>
<th>Advanced Privileges</th>
<th>Requested</th>
<th>Approved</th>
<th>#Not Approved</th>
<th>With Direct Supervision</th>
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<tr>
<td>Colposcopy</td>
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<td>Fetal Monitoring Interpretation (requires 1 time course offered by Kaleida (certification required))</td>
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<td>Insert or remove intrauterine device (IUD)</td>
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<td>Insert or remove subcutaneous birth control</td>
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<td>Perform amniotomy</td>
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<td>Perform endometrial biopsy</td>
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Name of Physician Assistant (Print)

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

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

_____ b) I, as Supervising 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 Signature Date

___________________________________ __________
Supervising Physician’s Signature Date

___________________________________
Supervising Physician’s Name (Print)

___________________________________
Chief of Service’s Signature Date

___________________________________
Advanced Practice Provider Committee Date