

Privileges For Allied Health Professionals

Name: _____

Please indicate with a check mark your qualifications and category of privileges requested.

Qualifications

To be eligible for core privileges as an Allied Health Professional, the applicant must meet one of the following qualifications:

1. Evidence of current state licensure (when appropriate) **and, either**
2. Evidence of case list and two years of First Assistant experience **or**
3. Completion of First Assistance training program **or**
4. National Certification as a First Assistant **or**
5. Successful Inclusion in the American Board of Registration of Electroencephalographic and Evoked Potential Technologist.

A request for Core Privileges as an Allied Health requires documentation of an employer/employee relationship with a designated supervising physician (or physicians) who is a member of the Harris Methodist Southlake Medical Staff. Core Privileges may only be carried out under direct supervision by a surgeon who agrees to be responsible for the Allied Health at all times while performing these privileges at the hospital.

SCRUB TECH / DENTAL ASSISTANT			
	Drape Patient		Dressing changes
	Set up surgical back, table and mayo		Provide patient education
	Pass surgical instrumentation from mayo		Update physician preference cards
	Retract		Remove and/or apply dressings and/or packing
	Assist with patient positioning		Taking of cultures
	Cut suture		Removal of sutures
	Handle suction and/or sponge surgical field		Removal of drains
	Assist surgeon in utilizing specialized equipment		Apply electro-cautery to instrument held by physician
	Remove suture under direction of surgeon		
REGISTERED NURSE FIRST ASSISTANTS			
	All requests of Scrub Tech		Use Instruments
	Handle Tissue		Suture
	Provide exposure		Drain Insertion
	Provide Hemostasis		

MEDICAL ASSISTANT			
	Offer counseling and education to meet patient needs		Assist physician in utilizing specialized equipment and post operative appliances
	Monitor the effectiveness of therapeutic interventions		

ELECTRODIAGNOSTIC TECH			
	Perform neurophysiological monitoring in the OR		Furnish surgeon with description of WAVE FORMS being recorded
	Assist in assessing the functional integrity of peripheral and/or central nervous system during vascular, orthopedic and neurosurgical procedures		Document in medical record the WAVE FORM description
	Services only provided on express request of the surgeon		

Acknowledgement of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at **Harris Methodist Southlake**, 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 a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed: _____

Date: _____

Credentials Committee Recommendations: Recommend Deny

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Signed: _____

Date _____

Signature of Supervising Physician _____ Date _____

Printed Name of Supervising Physician _____ *Date* _____

Signature of Supervising Physician _____ Date _____

Printed Name of Supervising Physician _____ *Date* _____

