

**Atrium Health Cleveland**  
**Privileges: Nurse Practitioner (Surgery)**

I have reviewed the DOP/Roster provided to me by MSS and confirm as indicated below:

- ☐ My DOP is accurate and reflects privileges relevant to my current practice
- ☐ I have listed privileges that should be removed:

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**If your roster indicates that you hold any of the privileges listed below, you must provide the maintenance criteria as described, in order to maintain the privilege. Your maintenance criteria and attestation must be returned together.**

**N/A – NO MAINTENANCE CRITERIA**

**STOP:**

**UNLESS YOU ARE REQUESTING NEW OR ADDITIONAL PRIVILEGES, YOU DO NOT NEED TO GO BEYOND THIS POINT**

# Atrium Health Cleveland

## Privileges: Nurse Practitioner (Surgery)

Name \_\_\_\_\_

### Qualifications

#### *Surgery Nurse Practitioner*

- Must be licensed with the North Carolina Board of Nursing and approved by the North Carolina Medical Board;
- Be employed by **Atrium Health Cleveland** with the supervising physicians on the active Medical Staff or be employed and supervised by an active Medical Staff member of **Atrium Health Cleveland**.

*Please check the procedure/disease classification for which you are requesting privileges.*

Privileges	Requested	Not Requested	Recm'd	Not Recm'd
1. Interview patient for Medical History				
2. Perform general screening physical exam				
3. Initiate and transcribe orders of sponsoring physician				
4. Order routine tests and procedures				
5. Dictate/write history, physical, progress note and discharge summary				
6. Screen and follow up on patient consults				
7. Perform general and ENT specialty exam				
8. Initial treatment of minor ENT problems				
9. Assist in surgery				
10. Respond to ER call				
11. Provide counseling related to health habits and supportive counseling				
12. Provide instruction on physicians orders related to areas such as diet, physical therapy, and use of physical adjuncts to therapy- nebulizers, vaporizers				
13. Assist in management of acute medical emergencies and critical care units in presence of physician employer				
14. Prescribe medications as authorized by NC Medical Board and within practice act.				
15. Telemedicine privileges are defined as privileges for the use of electronic communication or other communication technologies' to provide or support clinical care at a distance. Telemedicine privileges shall include consulting, prescribing, rendering a diagnosis or otherwise providing clinical treatment to a patient using telemedicine in accordance with all laws, regulations, hospital guidelines and the bylaws of the Medical and Dental Staff. <b>The Supervising Physician shall remain responsible for all clinical activity of the Allied Health Professional.</b>  PLEASE NOTE: Telemedicine activities require prior approval from the Facility Medical Executive Committee.				

# Atrium Health Cleveland

## **Identification of Nurse Practitioners:**

In accordance with NCMB Regulations and hospital bylaws, the nurse practitioner will display on is/her name tag or garment the title of "Nurse Practitioner" when providing clinical services.

Comments: \_\_\_\_\_  
\_\_\_\_\_

## **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 Atrium Health Cleveland, and

I understand that:

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.

I attest that I am not currently a user of illegal drugs or do not currently abuse the use of legal drugs.

I attest that I do not have a physical or mental condition which could affect my motor skills or ability to exercise the clinical privileges requested or that I require an accommodation in order to exercise the privileges requested safely and competently.

I attest that the information provided in my initial application or most recent reappointment is accurate and has not changed, specifically the disclosure questions relating to my licensure or registration, clinical privileges, participation in benefit programs, health status, liability, and work history.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

## **Sponsoring Physician (s):**

In my opinion, this applicant is physically and mentally capable of performing the current privileges requested.

\_\_\_\_\_  
Sponsoring Physician Date

\_\_\_\_\_  
Sponsoring Physician Date