Atrium Health Union

Name of Applicant:_____

Privileges/Procedures	*REQUESTED*	*COMMENTS*
Obtain and record patient history		
Collect and record data for consultation		
Dictate discharge summaries		
Write patient orders, as specified, in approved standing orders		
Accept, record and carry out verbal orders		
Write progress notes, with appropriate countersignature		
Perform or assist with therapeutic procedures and tests routinely accepted, within the practice of the supervising physician, according to demonstrated training and competence		
Provide patient teaching and instructions, and interpetation of physicians orders to patient/family and hospital staff		
Performing Trigger Point Injections Lumbar Region		
Minor joint and bursa injections		
Greater trochanteric bursa injections		
Shoulder injections		
Knee injections		
Prescribing appropriate medications		
Reprogramming spinal cord and peripheral nerve stimulators		
Perform Cardiopulmonary Resuscitation (CPR)		
Assist/Perform Advanced Cardiac Life Support (ACLS) in accordance with certification.		
Ordering other therapies when indicated		
Additional privileges requested:		

Acknowledgement of Practitioner

I have requested only those clinical privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at CHS UNION, and I understand that:

a. In exercising any clinical privileges granted and in carrying out the responsibilities assigned to me, 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 policies governing privileged allied health professionals.

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*** _____

ENDORSEMENT OF PHYSICAN EMPLOYER(S)/SUPERVISOR(S)

Signed _____ ***Date*** _____

Print your name here: _____

Signed _____ ***Date*** _____

Print your name here: _____