THE CENTER FOR ORTHOPAEDIC SURGERY

DELINEATION OF PHYSICIAN ASSISTANT PRIVILGES

NAME:_____

Please INITIAL beside each privilege you are requesting.

Req INITIAL	Description	Anesthesia Director		Medical Advisory Committee	
	First Assistant in Surgical Procedures including surgical closure				
	EKG, EKG interpretation monitoring				
	Hypotensive interventions				
	Hypothermia interventions				
	Insertion / Removal of LMA Device				
	IV Insertion: Administration of IV Medications				
	Paint Management, Medications (does not include anesthesia)				
	Perform History and Physical examination				
	Perform intubation and extubating				
	Perform pre-operative evaluation, assessment, and orders				
	Perform post-operative evaluations and discharge instructions				
	Request/order diagnostic laboratory studies				
	Perform life support functions, including CPR and induction and intubation procedures, CODE BLUE				
	Emergency endotracheal intubations				
	Render care within the scope of training in a medical emergency				
	Make referrals and request consultations				
	Select, order, and/or administer preanesthetic medications and fluids				

I hereby request the clinical privileges as indicated above. I understand that such privileges include rendering of all associated diagnostic and supportive measures necessary in the performance of privileges I have requested. I understand that any and all privileges granted to me shall be commensurate with my documented training and demonstrated competence, judgment and capabilities. The Medical Advisory Committee and the Executive Board reserve the right to grant or limit my privileges in accordance with my continuing performance in rendering of patient care.

_____ _____

Provider Name Date

_____ _____

Approval Medical Direction Executive Committee Date

_____ _____

Approval Anesthesia Director Medical Executive Committee Date