THE CENTER FOR ORTHOPAEDIC SURGERY

DELINEATION OF PRIVILEGES

PHYSICIAN ASSISTANT

NAME:________________________________

Please mark the checkbox for Requested or Not Requested beside each privilege.

Description	Requested	Not Requested
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		
Pain 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.

____ ____________________

Signature Date

____ ____________________

Supervising Physician Date