SCOTLAND HEALTH CARE SYSTEM
Collaborative Practice Agreement for Nurse Practitioners/Physician Assistants in the Scotland Orthopedics, and Surgical Service Setting

Name:_____ Effective From_____ to _____

QUALIFICATIONS:
To be eligible to apply for core privileges as a Physician Assistant, or Nurse Practitioner, the applicant must meet the following qualifications:

EDUCATION: Physician Assistant – Completion of Baccalaureate and Masters Degree
Nurse Practitioner – Completion of nurse practitioner training program

TRAINING: Physician Assistant – Graduation from an approved Allied Health Educational Program and current certification by the NCCPA.
Nurse Practitioner – NP master's degree or completion of formal post-graduate NP track or program within a school nursing granting graduate-level academic credit and national certification.

EXPERIENCE: The successful applicant must be able to document the satisfactory completion of PA/NP training within the past five years or document a minimum of 24 months of full-time practice as a Physician Assistant/Nurse Practitioner within the past five years.

CORE PRIVILEGES:

Physician Assistants/Nurse Practitioners provide initial and ongoing assessment/treatment of patients' medical, physical, and psychosocial status, including:

- Conducting/dictating histories and physicals
- Performing rounds
- Preparing/dictating discharge summaries
- Interdisciplinary consulting/conferences
- Developing/implementing treatment plans
- Writing daily progress notes
- Counseling/educating patients/families/significant others

Physician Assistants/Nurse Practitioners may implement physician-directed treatment plans that permit them to:

- Order medications, treatments, diagnostic studies, lab work, IV fluids, etc. (Countersigned by supervising physician within chart completion time parameters as stipulated by current Health Information Management policy)
- Provide basic/advanced cardiac life support (if ACLS certified)
- Provide pre and post operative surgical care
- Perform standard clinical procedures to include, but not limited to, Venipuncture, arterial gases, administering local infiltrative anesthesia, placement of peripheral IV lines, electrocardiogram recording, urinary catheter placement, intradermal tests, IM/Sub Q injections, application of dressings, wound care, suture of uncomplicated superficial lacerations (not involving major nerves, arteries or tendons), removal of sutures, removal of IVs/soft tissue drains/ nasogastric tube management, tracheal suction, enteral/parenteral nutrition, tracheostomy care/tube changes
- Medication instillation via oral, NG, IM, IV, intradermal, chest tube, endotracheal tube

NOTE: The performance of a PA/NP shall be under the direction of the sponsoring physician or his/her designee.

_____I am requesting Core Privileges as a Physician Assistant
_____I am requesting Core Privileges as a Nurse Practitioner

SPECIAL REQUESTS
Physician Assistants/Nurse practitioners may request approval to perform the following "special requests" provided they can document training and recent experience (performed in the previous year) in each procedure requested. Documentation should

be in the form of correspondence from the director of the applicant's training program or the previous sponsoring physician and should specifically detail for each special request the number of procedures performed and the applicant's competency.

Precepting Option: **Individuals who are qualified for core privileges but are unable to document experience as outlined for special requests procedures may obtain required experience under direct supervision of physician sponsor. Upon completion of preceptorship for desired privileges applicant is to submit a request for additional privileges accompanied by letter from preceptor supporting request and confirming competence. Please clearly distinguish below any procedures requested via this precepting option.**

Indicate below the procedures requested:

Noninvasive/Invasive Procedures (Initial beside requested procedures)	**Required # Local (SMH) Under Observed Physician Supervision**	**SMH Primary or other qualified physician Physician signature required to first apply for PROVISIONAL privilege of any procedures with required # (SMH)**	**SMH Primary or other qualified physician Physician signature required to apply for FULL privilege, once criteria have been satisfactorily met for procedure.**
[ ] Irrigation & packing of superficial wounds			
[ ] Apply and remove casts and splints			
[ ] Apply and remove Orthopaedic Braces			
[ ] Assist with Reduction of Fractures & Dislocations			
[ ] Wound V.A.C Placement			
INVASIVE PROCEDURES			
[ ] Anoscopy			
[ ] Chest Tube Placement			
[ ] Debridement of Wounds including surgical debridement			
[ ] Dermatological Biopsies			
[ ] External Jugular Vein Cannulation			
[ ] Femoral Vein Cannulation			
[ ] Incision, Irrigation and Drainage of Abscess			
[ ] Fracture Hematoma Block			
[ ] Joint Injections/ Aspirations			
[ ] Needle Aspiration of Pneumothorax			
[ ] Percutaneous Arterial Catheterization Catheter Insertion			
[ ] Percutaneous Central Venous Catheter Insertion			
[ ] Perm Cath Removal			
[ ] Rectal Exam			
[ ] Removal of superficial foreign bodies soft tissues			
[ ] Surgical Assistant (with appropriate education and training)			
[ ] Suturing and/or Stapling Superficial Wounds			
[ ] PICC line placement			

[ ]			
[ ]			
[ ]			

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 this facility, 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: _____
(Physician Assistant/Nurse Practitioner)

Sponsoring Physician Statement:
I have reviewed this applicant's request for appointment to the Medical Assistant Staff and agree that all duties and appointments as outlined will be necessary in the performance of this applicant's duties as my Physician Assistant/Nurse Practitioner. I understand that I am responsible for the clinical performance and competence of this individual and I agree to assume responsibility for this applicant in the carrying out of duties as outlined.

Signed:_____ Date: _____
(Sponsoring Physician)

Names/Signatures of Secondary Sponsors:

Name:_____ Signature:_____
Name: _____ Signature: _____
Name: _____ Signature: _____

Department chair's recommendations
Based on the information provided, I find the applicant to be: [ ] Qualified [ ] Not qualified for the privileges requested.

☐ Requested	☐ Recommended	☐ Not Recommended
[ ] Recommended with Exceptions:		

Department Chair's Signature: _____Date:_____

……**FOR MEDICAL STAFF OFFICE USE**…….
Credentials Committee Action:_____ Date:_____
Medical Executive Committee Action:_____Date:_____
Board of Trustees Action:_____ Date:_____

REVISED 03/09