**LAC+USC MEDICAL CENTER ATTENDING STAFF ASSOCIATION**
**DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF NEUROSURGERY**
**NURSE PRACTITIONERS**

**NAME OF APPLICANT ___________________________________________________ DATE______________________________________________

[ ] Initial Appointment and/or Additional Privileges   [ ] Reappointment

**Applicant:** Check off only those privileges expected to be performed at the site where you will be working. Note that privileges granted may only be exercised at the site(s) and setting(s) recommended by the Department Chair/Chief/Designee. Shaded areas indicate that the privilege is not applicable for that particular entity.

**Department Chair/Chief/Designee:** Initial the Recommended column for approved privileges. If applicable, check off the “Not Recommended” boxes. Documentation of all privileges must be provided for all privileges on the last page of this form.

<table>
<thead>
<tr>
<th>REQUESTED</th>
<th>DESCRIPTION OF PRIVILEGE</th>
<th>RECOMMENDED</th>
<th>NOT RECOMMENDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAC+USC Medical Center</td>
<td>Follow department guidelines and standardized procedures, policies and protocols found in the Advance Practice Nursing Policy and Procedures Manual.</td>
<td>Competency</td>
<td>Other</td>
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<td><strong>Core Privileges:</strong> Basic privileges in Neurosurgery include:</td>
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<td>- Conduct patient and family education,</td>
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<td>- Determine assessment and interval for follow up,</td>
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<td>- Document care rendered in medical record, and</td>
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<td>- Complete discharge summaries of patients.</td>
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for the following ages:

- Neonates and Infants from 0 to 2 years of age
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<tbody>
<tr>
<td>LAC+USC Medical Center</td>
<td>Children from 3 to 13 years of age</td>
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<td>Adolescents and Adults 14 years of age and older</td>
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<td>Furnishing of written orders for medications and medical devices</td>
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**AREA OF SPECIALIZATION**

Neurosurgery

**SPECIFIC PRIVILEGES**

1. Management of central lines (CVP) and arterial lines
2. Perform intubations
3. Placement and management of chest tubes
4. Placement and management of ventriculostomies including installation of antibiotics and flushing of catheters
5. Assist in placement of tracheostomies
6. Perform as First and/or Second Surgical Assistant for neurosurgical cases (requires certificate)
7. Perform lumbar puncture
8. Perform shunt taps
9. Suture and perform I&D procedures as necessary
<table>
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<th>RECOMMENDED</th>
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</thead>
<tbody>
<tr>
<td>LAC+USC Medical Center</td>
<td>10. Wound management including debridement</td>
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<td>11. Placement and management of urethral catheters</td>
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<td>12. Perform urodynamic procedures</td>
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<td>13. Biopsy</td>
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<td>14. Cystoscopy</td>
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**PRIVILEGES NOT INCLUDED ON THIS FORM:** A request to perform any procedure or treatment not included on this form must be submitted to the Attending Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.

**TEMPORARY CLINICAL PRIVILEGES:** In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient’s life or to save a patient from serious harm, regardless of staff status or privileges granted as per the LAC+USC Attending Staff Association Bylaws.

**ACKNOWLEDGMENT OF PRACTITIONER:**
I hereby certify that I have no physical or mental impairment which would interfere with my practice, and 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 in each group of procedures requested. I understand that in making this request I am bound by the LAC+USC Bylaws and/or policies of the hospital and medical staff.

_______________________________________________________________  _________________
Applicant’s Signature          Date

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

_______________________________________________________________  (Signature)  _________________
Supervising Physician (print)          Date

Name: ________________________________
Department Chair/Chief/Designee recommendation:

If there are any recommendations of privileges that need to be modified or have conditions added, indicate here:

Privilege#:  
Condition/Modification/Explanation:  

If privileges are NOT recommended based on COMPETENCY, provide explanation:

Privilege#:  
Explanation for NOT recommending based on COMPETENCY:  

If supplemental documentation provided, check here:  

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

SIGNATURE OF THE DEPARTMENT CHAIR/CHIEF/DESIGNEE                 DATE

APPROVED BY INTERDISCIPLINARY PRACTICE COMMITTEE ON:  
APPROVED BY EXECUTIVE COMMITTEE ON:  
APPROVED BY GOVERNING BODY ON:  
PERIOD ENDING:  

Name:  

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