LAC+USC MEDICAL CENTER & HEALTHCARE NETWORK ATTENDING STAFF ASSOCIATION
DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF SURGERY
PHYSICIAN ASSISTANTS

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.

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				Physician Assistant's (PA) , in accordance with the Delegation of Services Agreement between the PA and the Supervising Physician, may provide any legal medical service that is within the PA's scope of medical practice. **Core Privileges**: Basic privileges in Dermatology include: - Institute treatment essential for the life of the patient (i.e. BCLS), - Transfer patients to observation areas and between hospital units, - Obtain a history, - Perform a physical examination, - Order laboratory and diagnostic procedures, - Interpret laboratory data, - Interpret diagnostic studies, - Obtain informed consent for procedures, - Perform and/or assist in the performance of diagnostic studies within the scope of specialty services, - Perform and/or assist in the performance of therapeutic procedures within the scope of specialty services, - Monitor patients throughout procedure and during recovery period, - Determine assessment and interval for follow up, - Conduct patient and family education, - Manage and provide consultations, - Document patient interactions, - Document care rendered in medical record, and - Complete discharge summaries of patients. for the following ages:			
				Neonates and Infants from 0 to 2 years of age			

M = LAC+USC Medical Center
E = El Monte Comprehensive Health Center
H = Hudson Comprehensive Health Center
R = Roybal Comprehensive Health Center

Name: _____

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				Children from 3 to 13 years of age			
				Adolescents and Adults, 14 years of age and older			
				Transmital of written orders for medications and medical devices			
				AREA OF SPECIALIZATION - SURGERY			
				1. Acute Care Surgery			
				2. Cardiac Surgery			
				3. Colorectal			
				4. Hepatobiliary			
				5. Plastics and Burns			
				6. Thoracic/Minimally Invasive Surgery			
				7 Surgical Oncology			
				8. Vascular			
				SPECIFIC PRIVILEGES - SURGERY			
				1. Surgical assist			
				2. Superficial biopsy according to service			
				3. Debridement of wound			

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REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				4. Placement of arterial lines			
				5. Perform intubations			
				6. Placement of chest tubes			
				7. Perform I & D procedures			
				8. Perform simple suture			

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 attending staff. Privileges as granted will be practiced in accordance with department procedures.

_____ _____

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.

_____ _____ _____

Supervising Physician (print) (Signature) Date

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REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other

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:

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