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

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				Follow department guidelines and standardized procedures, policies and protocols found in the Advance Practice Nursing Policy and Procedures Manual**.** **Core Privileges**: Basic privileges in Orthopedic Surgery include: - Work with housestaff to facilitate timely discharge, - Coordinate surgical scheduling with attendings and housestaff, - Monitor patients throughout procedure and during recovery period, - Complete discharge summaries of patients. - Transfer patients to observation areas, - Obtain a history, - Perform a physical examination, - Order laboratory and diagnostic procedures, - Interpret laboratory data, - Interpret diagnostic studies, - Institute treatment essential for the life of the patient (i.e. ACLS), - 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, - 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 for the following ages:			
				Adolescents and Young Adults 14 years of age and older			

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

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				Furnish drugs and devices			
				PROCEDURES			
				1. First surgical assistant (certificate required)			
				2. Superficial biopsy according to service			
				3. Debridement of wound			
				4. Perform I & D procedures			
				5. Perform simple suture			
				6. Second Assistant Surgery			

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.

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Name: _____

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

_____ _____

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

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: ☐

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Name: _____

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

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 CREDENTIALS & PRIVILEGES COMMITTEE ON:	APPROVED BY EXECUTIVE COMMITTEE ON:
APPROVED BY GOVERNING BODY ON:	PERIOD ENDING:

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Name: _____