Providence Hospital
of North Houston

Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_____ _____
Print Name Date

Privilege Request Form – Surgical Assistant

SECTION I – GENERAL REQUIREMENTS SURGICAL ASSISTANT

Basic Education: SA

INITIAL APPOINTMENT

Minimal formal training and experience:

- Licensed as a Surgical Assistant through the Texas State Board of Medical Examiners; OR
- Certified by the American Board of Surgical Assistants or the National Surgical Assistant Association.

REAPPOINTMENT MAINTENANCE OF PRIVILEGE

- Demonstrated evidence of clinical activity from relevant professional practice evaluation during the past 24 months without significant quality variations, OR
- Satisfactory Annual reviews of performance from the sponsoring physician; and
- Ongoing maintenance of continuing medical education as it pertains to scope of license and specialty.

SECTION II – PRIVILEGES REQUESTED

Exercise of Clinical Privileges:

- Surgical Assistants may assist the supervising physician during an operation within the scope of clinical privileges granted by the Hospital, but may not perform any portion of the procedure independently.
- Clinical privileges may only be exercised upon request of the supervising physician and shall be carried out to the direct control and supervision of the supervising physician.

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- All order entries in the medical record must be countersigned by the physician within 24 hours.

- Surgical Assistant shall be documented and identified on the OR record as a Surgical Assistant.
- May not:
    - Independently prescribe medications or treatments;
    - Serve as a substitute for the supervising physician;
    - Engage in the practice of medicine;
    - Make medical rounds in substitution for the supervising physician;
    - Inhibit or in any way interfere with the responsibilities and duties of the Hospital employee;
    - Establish an office, work space or location for exclusive use at the Hospital; AND
    - Independently admit or discharge patients.

Basic Privileges:

By requesting these privileges, the supervising physician is attesting that he/she has knowledge of the education, training, ability and competence of the Surgical Assistant. The physician is also attesting that granting these clinical privileges is consistent with current medical practice and will not adversely affect patient safety and tat he/she shall be legally responsible and accountable for all of the clinical activities performed by the Surgical Assistant, including ensuring that the Surgical Assistant performs only those clinical privileges that have been approved and granted.

All clinical privileges shall be performed under the direct supervision of the supervising physician.

Procedures	Requested	Granted	Denied
Assist with positioning of patient			
Opening of sterile supplies			
Surgical scrub – gowning/gloving			
Surgical draping of patient			

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Visualization of surgical site – sponging, retraction, suction, cauterization, clamping			
Suture tying, cutting			
Application surgical dressing			
Assist with movement of patient to stretcher/bed			

I have been approved for these procedures at the following hospitals/ambulatory surgery centers:

SECTION III - ACKNOWLEDGE OF PRACTITIONER:

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at the Hospital. I hereby attest that the references, reports, records and information are available that verify my qualifications and competency to practice as requested.

I understand that:

1. In exercising any clinical privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

2. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.

3. The use of any other new, untried, or unproven procedure/treatment modality/instrumentation maybe performed or used, only after the regular credentialing process has been completed and the privilege to perform or use said procedure/treatment modality/instrumentation has been granted to the individual practitioner.

SUPERVISING PHYSICIAN (PRINTED NAME): _____

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_____ _____
Print Name Date

PHONE # OF SUPERVISING PHYSICIAN: _____

_____ _____
SIGNATURE OF APPLICANT **DATE**

_____ _____
SIGNATURE OF SUPERVISING PHYSICIAN **DATE**

SECTION IV – RECOMMENDATIONS AND APPROVALS

Recommendation of the Medical Director:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

_____ Approval of all requested privileges

_____ Approval of the following privileges with conditions:
_____

_____ Denial of the following privileges:
_____

_____ _____
Medical Director **Date**

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_____ _____
Print Name Date

Recommendation of the Medical Executive Committee:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

_____ Approval of all requested privileges

_____ Approval of the following privileges with conditions:
_____

_____ Denial of the following privileges:
_____

_____ _____
Chief of Staff **Date**

Decision of the Governing Board:

The Governing Board has reviewed the above recommendations regarding the requested clinical privileges and supporting documentation for the above named applicant and has:

_____ Granted all requested privileges

_____ Granted the following privileges with conditions:
_____

_____Denied the following privileges:
_____

_____ _____
Chairman of the Board **Date**