Huntington Memorial Hospital

Delineation Of Privileges
Physician Assistant Privilege Form

Provider Name:

<table>
<thead>
<tr>
<th>Privilege</th>
<th>Requested</th>
<th>Deferred</th>
<th>Approved</th>
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</table>

**JOB SUMMARY:** A physician assistant (PA) may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patient's care by the PA.

**CATEGORY 1 SERVICES** - Physician Assistant:
*Qualifications:* Requires completion of an accredited training program as a Physician Assistant; Current licensure by the Medical Board of California Physician Assistant Committee as a Physician Assistant (PA); Physician sponsorship (must be Active status in good standing at HMH); Certification by the applicants Training director and the sponsoring physician that the applicant is competent to perform the requested services; and Current BCLS Certification by the American Heart Association.

**INITIAL COMPETENCY ASSESSMENT:** Successful evaluation by Sponsoring Physician of at least ten (10) representative cases in which the PA has provided Category 1 Services. Category 2: 6 fo each Category 2 cases proctoring is required by direct observation. Category 3: Proctoring by direct observation. PA will remain on Provisional status until the initial competency assessment is completed and may NOT be advanced to Active status before he/she has been on staff for a period of six months.

**CONTINUED COMPETENCY EVALUATION:** Activity of at least 30 patients per year; Satisfactory Evaluation of that care by the Supervising Physician; Review of any applicable Quality Monitoring conducted by Huntington Hospital; and Review of any adverse events.

**CATEGORY 1 - Specified Services:**

Take a patient history; perform a physical examination and make an assessment therefrom; initiate, review and revise treatment and therapy plans including plans for those services described below; and record and present pertinent data in a manner meaningful to the physician.

Transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services.

Transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.

Recognize and evaluate situations which call for the immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient including BCLS, and will notify supervising physician immediately.
Instruct and counsel patients regarding matters pertaining to the physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging and understanding of and long term management of their diseases.

Initiate arrangement for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.

Initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community.

Administer medication to a patient, or transmit orally, or transmit in writing on a patient's record, a prescription from his or her supervising physician to a person who may lawfully furnish such medication or medical device.

**Must have DEA and have Formulary on file approved by the IDP Committee**

Assist Code Blue Team

Apply Splints and Casts

Suture minor lacerations

Deliver care under pre-approved protocols that have been reviewed and accepted by the Supervising Physician and the IDP Committee.

**Requires 10% Chart Review with counter signature by the Supervising Physician**

**CATEGORY 1 - Specified Services that may ONLY be performed in the presence of the sponsoring MD.**

Assist in Surgery

Assist in deliveries

Assist in management of injuries
## Huntington Memorial Hospital

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<tbody>
<tr>
<td>Assist in acute emergencies</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Assist in Critical Care Units</td>
<td>___</td>
<td>___</td>
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**CATEGORY 2 - Services**

- Spinal Tap / Lumbar Puncture: ___ ___ ___
- Paracentesis: ___ ___ ___
- Thoracentesis: ___ ___ ___
- Bone Marrow Aspiration / Biopsy: ___ ___ ___
- Pap Smear: ___ ___ ___
- Percutaneous Venous Lines: ___ ___ ___
- Percutaneous arterial lines: ___ ___ ___
- Venous Cutdowns: ___ ___ ___
- Arterial Cutdowns: ___ ___ ___
- First Assist: ___ ___ ___
- Insertion Balloon Pump: ___ ___ ___
- Open Vein Harvesting: ___ ___ ___
- Removal Pacemaker wires: ___ ___ ___
- Insertion / removal chest tubes: ___ ___ ___

**CATEGORY 3 - Services**

- Endoscopic Vein Harvesting: ___ ___ ___
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<tr>
<td>ACLS (Current Certification Required)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PALS (Current Certification Required)</td>
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ACKNOWLEDGEMENT OF THE ALLIED HEALTH PROFESSIONAL:

I have requested only those privileges for which I am qualified to perform, based upon my education, training, current experience and demonstrated performance. I understand that in exercising my practice privileges granted, I am constrained by hospital and medical staff policies and rules, including those outlined in the Allied Health Professional Rules and Regulations.

Signature of AHP: ___________________________________________  Date: _______________

Signature of Supervising Physician: ____________________________  Date: _______________

INTERDISCIPLINARY PRACTICE COMMITTEE RECOMMENDATION:

I have reviewed the requested practice privileges and supportive documentation for the above names applicant and recommend action on the privileges as noted above.

Applicant may perform practice privileges as indicated: __________ YES    __________ NO

Exceptions/Limitations (Please Specify): ____________________________

____________________________________________________________________________________________

APPROVALS

Interdisciplinary Practice Committee: _____________________________  Date: __________
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Medical Executive Committee Date: ______________

Board of Directors Date: _________________________