Huntington Memorial Hospital

Delineation Of Privileges
Registered Nurse Private Scrub

Provider Name:

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<th>Privilege</th>
<th>Requested</th>
<th>Deferred</th>
<th>Approved</th>
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**JOB SUMMARY:**
The Private Scrub Nurse is responsible and accountable for the delivery of individualized nursing care to the patients having surgical intervention. Incorporating current clinical knowledge with established nursing practice, he/she performs nursing interventions utilizing the nursing process. The Private Scrub Nurse works directly under the supervision of the employing surgeon. He/she is indirectly under the supervision of the Director of Peri-operative Services for proper aseptic technique and adherence to operating rules & regulations.

**QUALIFICATIONS:**
Current License through the California Board of Registered Nursing and at least 1 year experience acting as an operating nurse or graduate of program.
Current BLS certification required.

1. Care of surgical instruments. ___ ___ ___
2. Prepping of patients as appropriate to specialty and procedure. ___ ___ ___
3. Opening of sterile supplies. ___ ___ ___
4. Passing of instruments. ___ ___ ___
5. Cutting ends of suture after surgeon places suture. ___ ___ ___
6. Holds retractors. ___ ___ ___
7. Sunctions wounds. ___ ___ ___
8. Placement of post-op dressing. ___ ___ ___
9. Administers medications as prescribed by sponsoring physician. ___ ___ ___
10. Participates in discharging planning with patients dosage, possible side effects, follow-up visits and outpatient testing. ___ ___ ___

**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
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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: __________

Medical Executive Committee Date: __________

Board of Directors Date: ________________