



**REQUEST FOR CLINICAL PRIVILEGES: CERTIFIED NURSE PRACTITIONER**

Name (please print): \_\_\_\_\_

**Instructions: Place a ( √ ) next to each procedure requested.**

| Procedure Classification   | Privilege Requested | Privilege Recommended | Special Conditions |
|--|---------------------|-----------------------|--------------------|
| History collection and physical examination, patient assessments                         |                     |                       |                    |
| Administration of chemotherapeutic agents  |                     |                       |                    |
| Removal of chest tubes   |                     |                       |                    |
| Removal of central lines   |                     |                       |                    |
| Assisting in minor surgeries   |                     |                       |                    |
| Functioning as a scrub nurse in any case where Dr. Karl Gutierrez is the primary surgeon |                     |                       |                    |
| Placement of casts and splints   |                     |                       |                    |
| Simple suturing  |                     |                       |                    |
| Write orders without physician counter signature   |                     |                       |                    |
| Insertion of arterial lines  |                     |                       |                    |
| Wound debridement  |                     |                       |                    |
| Placement of PICC lines  |                     |                       |                    |

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**Appointment Recommended**    **Appointment Not Recommended**    **Appointment Deferred**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chairman, Executive Committee

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**Appointed**

**Disapproved**

**Deferred**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chairman, Board of Directors



**HEALTH STATEMENT**

Do you presently have a physical or mental health condition which would affect or is likely to affect your ability to perform professional or medical staff duties as a physician/allied health professional?:

\_\_\_\_\_ Yes    \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

During the last two years, have you been hospitalized or received any other type of institutional care for a health problem?:

\_\_\_\_\_ Yes    \_\_\_\_\_ No

Significant finding: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_

**\*\*\*\*\*IMPORTANT – MUST BE SIGNED BY VERIFYING PHYSICIAN\*\*\*\*\***

I affirm to the best of my knowledge that the above mentioned physician has no physical or psychological impairments that would impede his/her ability to perform quality health care services.

\_\_\_\_\_  
(Signature of verifying physician)

Date: \_\_\_\_\_