



One of the Northwest's Best

LANE REGIONAL MEDICAL CENTER
 DELINEATIONS
 RN/LPN

APPLICANT'S NAME: (Please Print) _____

SPONSORING PHYSICIAN'S NAME: (Please Print) _____

Please check specialty: Registered Nurse Licensed Practical Nurse

- Criteria:
- * Documentation of graduation of an accredited nursing program
 - * Current license from State Board of Nursing
 - * Functions under the direct supervision of the sponsoring physician carrying out protocols established and approved by the Medical Staff Executive/Bylaws Committee.
 - * Shall adhere to all Medical Staff Bylaws, Rules and Regulations. Failure to comply may result in withdrawal or modification of privileges for both RN/LPN and sponsoring physician.

CHECK FUNCTIONS REQUESTED AS THEY APPLY TO SPECIALITY:

The listing of functions for physician's employees – Registered Nurses and Licensed Practical Nurses, is not all inclusive and may be changed from time to time through addition or deletion.

	Requested	Approved
Access to Medical Records:		
Dictate/Write Progress Notes (under the immediate direction of sponsoring physician be countersigned by physician within 24 hours)	_____	_____
Duties that may be performed only in the presence of physician employer:		
Apply Casts	_____	_____
Apply traction apparatus	_____	_____
Assist with diagnostic procedure	_____	_____
Assist in surgery –Operating Room		
First assistant	_____	_____
Second assistant	_____	_____
Scrub nurse	_____	_____
Assist in surgery – Duties		
Arrange for delivery of surgical instruments	_____	_____
Cut sutures	_____	_____
Prepare instruments sets for sterilization	_____	_____
Prepare sterile instrument set-up	_____	_____
Retract tissue	_____	_____
Sponge operative sites	_____	_____
Apply surgical dressing	_____	_____
Change surgical dressings in OR suite	_____	_____
Responsible for care of surgeons' instruments after procedure	_____	_____
Transcribe orders (under the immediate direction of sponsoring physician be countersigned by physician within 24 hours)	_____	_____

Nursing Duties:

Perform nursing functions (within the limitations of the law of the State of Louisiana and as detailed in hospital policy.)

Patient contact/instruction:

Instruct in the following areas:

- Diets
- Discharge Planning
- Education concerning patient's disease entity
- Exercises
- Follow up planning
- Medications

Provide health counseling and guidance

Procedures (without physician present):

- Do dressing changes
- Insert, remove or change catheters
- Remove or shorten drains
- Remove packs with physician's order
- Remove sutures/staples

Others:

- Assist physician in patient rounds on floor and in ER
- Assist physician with physical exams and procedures
- Dictate admission H&Ps and Discharge Summaries
(to be countersigned by physician within 24 hours)
- See consults and obtain history (under direction of sponsoring physician)
(to be countersigned by physician within 24 hours)

Applicant Signature _____

Date _____

Sponsoring Physician Signature _____

Date _____

STATEMENT OF CONFIDENTIALITY

It is the policy of Lane Regional Medical Center and the Medical Staff that any and all information concerning a patient of the facility is of a strictly confidential nature. THIS APPLIES TO VERBAL, WRITTEN OR FAX TRANSMISSIONS. Confidentiality is a right entitled to each patient beginning at admission or upon making a reservation for admission and the right is never terminated. It is the duty and responsibility of every physician, employee and volunteer of Lane Regional Medical Center to ensure that right, both at work and off duty.

By signing below, I signify that I understand and agree to the following:

1. I acknowledge that all information in the patient record (a medical/legal document) including evidence of patient identity as well as the course of clinical treatment is strictly confidential. I will abide by the policy of Lane Regional Medical Center and I will not jeopardize the patient's right to confidentiality (either verbally, in writing or via Fax transmission) of any information which may be used to identify a patient.
2. I agree that in reviewing records, data or hospital documents containing patient information that this information will be used only for the treatment of the patient.
3. I further understand that I could be subject to legal action for violation of any confidences related to patient information.

Name _____
(Please Print)

Signature

Date