

CARLSBAD MEDICAL CENTER

CERTIFIED FIRST ASSIST IN SURGERY (CFA)
JOB DESCRIPTION

NAME OF APPLICANT: _____

SUPERVISING PHYSICIAN: _____

CERTIFICATION: _____

LICENSURE/CERTIFICATION/QUALIFICATIONS

The CFA may be eligible for approved functions if the CFA:

- a. Is certified as a Certified First Assist by the Liaison Council on Certification for the Certified First Assist;
- b. Can demonstrate sufficient training and experience to ensure competence in surgical assisting;
- c. Maintains continuing education to maintain certification;
- d. Has evidence of liability insurance with limits of 1/3;
- e. Has current BCLS Certification;
- f. Has current ACLS Certification.

APPOINTMENT/REAPPOINTMENT

Applicants for initial appointment and reappointment to the AHP Staff will be required to demonstrate sufficient training and experience to ensure competence. This assessment will include information from performance improvement activities which will include an assessment of the CFA's clinical judgement and skills. Competence may also be documented by the following:

- a. A letter from an individual with at least equal licensure and comparable training and current practice experience who has observed the applicant in the requested functions;
- b. letter from the program direction of the training facility;
- c. Continuing Education.

PROCTORING REQUIREMENTS

All provisional appointees shall undergo a period of observation/proctoring to determine clinical/technical competence. Members of the AHP staff requesting additional functions are required to be proctored for those functions. The terms and methods of proctoring are contained in the Allied Health Practitioner Staff Rules and Regulations, Article IV, and where applicable, the Medical Staff Policy on Proctoring.

SUPERVISING REQUIREMENTS

A Certified First Assist (CFA) will function under the direction of a supervising physician who is a member of the Carlsbad Medical Center Medical Staff.

JOB DESCRIPTION – CERTIFIED FIRST ASSIST

Please check the appropriate boxes related to those functions that you would like included in your job description.

R = Requested

G = Granted

D = Denied

PROCEDURAL FUNCTIONS

R	G	D	
INTRAOPERATIVE			
[]	[]	[]	Assist with patient positioning, skin preparation and draping the patient
[]	[]	[]	Provide retraction for adequate exposure
[]	[]	[]	Use of Surgical Instruments
[]	[]	[]	Perform Dissection
[]	[]	[]	Suture
[]	[]	[]	Provide hemostasis
[]	[]	[]	Provide Closure of the Surgical Wound
[]	[]	[]	Assist with affixing and stabilizing drains, cleaning the wound and applying the dressing and applying casts.

POSTOPERATIVE			
[]	[]	[]	Remove dressing sutures, skin staples, drains, chest tubes and casts

MISCELLANEOUS			
[]	[]	[]	Perform other functions according to practice protocols adopted by the Hospital.

I certify that I have had the necessary training and experience to perform the job description functions I have requested. I agree to abide by the Allied Health Professional Rules and Regulations, the Medical Staff Bylaws, Rules and Regulations and Hospital Policies and will provide only services within the scope of my licensure and/or practice.

Signature: _____ Date: _____

I have reviewed the above described functions and agree to supervise _____ in the performance of the approved functions.

Supervising Physician Signature: _____ Date: _____

APPROVALS

All functions have been individually considered and have been recommended based upon the Practitioner's licensure/certification, specific training, experience, health status, current competence and peer recommendations.

APPLICANT MAY PERFORM THE FUNCTIONS AS INDICATED:

Exceptions/Limitations: (Specify) _____

Department of Surgery Date

Medical Executive Committee Date

Board of Trustees Date



AUTHORIZATION FOR BACKGROUND CHECK

By signing below, I grant permission to the Hospital, its medical staff and representatives ("Hospital") to obtain an investigative report, to include state and federal criminal records and driving arrest records, for purposes of processing my medical staff application. I understand that I may request the Hospital to disclose the nature and scope of the investigation requested within five (5) days of my written request made within a reasonable time after the Hospital obtains the information. I also understand that I am entitled to request a summary of my rights with respect to consumer reporting agencies.

Print Name

Signature

Date