

CARLSBAD MEDICAL CENTER

PHYSICIAN ASSISTANT – SURGERY
JOB DESCRIPTION

NAME OF APPLICANT: _____

SUPERVISING PHYSICIAN: _____

CERTIFICATION: _____

LICENSURE/CERTIFICATION/QUALIFICATIONS

The Physician Assistant in Surgery may be eligible for approved functions if the Physician Assistant:

- a. is licensed as a Physician Assistant by the New Mexico Board of Medical Examiners;
- b. is certified by the National Commission on Certification of Physician Assistants (NCCPA);
- c. Maintains Continuing Education as required for licensure/certification;
- d. Has evidence of liability insurance with limits of \$200,000/\$600,000.
- e. Has filed a current "Application for Approval as a Supervising Physician" with the New Mexico Board of Medical Examiners as required.
- f. Is current BLS Certified;
- g. Is current ACLS Certified.

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 PAs clinical judgement and skills. Competency 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 clinically observed the applicant in the requested functions;
- b. a letter from the program director of the training facility;
- c. Continuing Education programs.

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.

SUPERVISION

A physician will be responsible for the supervision of the PA and accepts full responsibility for the Physician Assistant's performance of all professional services, duties and acts. Supervision is defined as the responsibility of the supervising physician to review with the PA the findings of the patient's history and physical examination and the performance by the PA of approved tasks/procedures/duties and review of the PA written record of these findings and the procedures performed. The supervising physician shall have the responsibility to document that supervision has been provided and to co-sign each chart as evidence of same.

JOB DESCRIPTION –PHYSICIAN ASSISTANT IN SURGERY

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

R = Requested

G = Granted

D = Denied

GENERAL COGNITIVE

R	G	D	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Diagnosis and Treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pediatric
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History and Physical Assessments
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Instruction and Patient Counseling
			Provide instruction and counsel patients regarding matters pertinent to their physical and mental health and may include topics such as medication, diet, social habits, family planning, normal growth development, aging and understanding of and long-term management of their disease.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prescriptive Authority
			Furnish drugs or devices including controlled substances according to section 7.7-5 of the Allied Health Professional Rules and Regulations.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Facilitation of Care
			Facilitate hospital and outside staff in initiating referrals to appropriate health care agencies arranging community resources, facilitating continuing care and addressing other issues of long-term care placement.

PROCEDURAL FUNCTIONS

Documentation of specific training and experience is required for all procedural privileges requested.

R	G	D	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Application of::
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy Modalities
			Traction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Casts, Removal of
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Catheterization, Urethral
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Culturals, Taking of
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incision and Drainage of Infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injections and Immunizations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laceration Repair, Simple, (after consultation with the supervising physician)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Removal of Foreign Bodies from skin, ear and nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Sprains:</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Casting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Splinting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strapping

NAME OF PRACTITIONER: _____

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R **G** **D**
[] [] []

Surgical Assisting (first or second under supervision of the supervising physician)

Wound Care:

[] [] []
[] [] []
[] [] []
[] [] []

Debridement
Hemorrhage
Removal of Sutures
Suturing

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 Practitioner 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