SSM ST. CLARE SURGICAL CENTER

ALLIED HEALTH PROFESSIONAL STAFF

JOB DESCRIPTION

(Attach an additional sheet if necessary)

Outline the description of duties to perform at The Center, the scope of practice and level of supervision.

Requested		**Privilege/Procedure Description**	**Approved**		**Deferred**
Yes	**No**	All duties allowed by the Health Related Board of MISSOURI.			

If deferred, explanation provided:

_____

_____

_____

Printed Name of Allied Health Professional

Signature of Allied Health Professional: Date:

STATEMENT OF EMPLOYING SUPERVISING PHYSICIAN:

I hereby verify that _____ is in my employment in the capacity of a surgical assistant/technologist. I agree to be fully responsible for the Allied Health Professional's actions in dealing with patients treated at the Center, and indemnify the Center against the actions or omissions of the Allied Health Professional staff member. I also agree to notify the Center if this person should ever leave my employment.

Printed Name of Supervising Physician:

Signature of Supervising Physician: Date:

Governing Body Approval Date: