

WEST JEFFERSON MEDICAL CENTER
ALLIED HEALTH PROFESSIONAL STAFF
REQUEST FOR AUTHORITY TO PROVIDE
PATIENT CARE SERVICES

CERTIFIED OPHTHALMIC TECHNICIAN

Applicant's Name (PRINT)

Date

Requested:

Approved:

ASSIST - UNDER DIRECTION OF SURGEON IN O.R.

- | | | |
|-------|---|-------|
| _____ | Apply electro-cautery to instrument held by surgeon | _____ |
| _____ | Retract | _____ |
| _____ | Cut suture | _____ |
| _____ | Handle suction and/or sponge surgical field | _____ |
| _____ | Apply dressings and packings | _____ |
| _____ | Assist surgeon in utilizing specialized equipment | _____ |
| _____ | Organize instrumentation and supplies | _____ |
| _____ | Set up surgical back table and Mayo | _____ |
| _____ | Pass surgical instrumentation from mayo (1st Scrub) | _____ |
| _____ | Drape patient | _____ |
| _____ | Assist with patient positioning | _____ |
| _____ | Assist with shaving and marking | _____ |
| _____ | Break down surgical field, deliver instruments
to instrument room for reprocessing | _____ |

Requested:

Approved:

MAY PERFORM INDEPENDENTLY AT THE DIRECTION OF PHYSICIAN
WITHOUT DIRECT SUPERVISION

- | | | |
|-------|--|-------|
| _____ | Dressing changes | _____ |
| _____ | Take wound cultures | _____ |
| _____ | Remove suture at direction of surgeon | _____ |
| _____ | Remove packing | _____ |
| _____ | Provide patient education | _____ |
| _____ | Collect patient information and test results for the physician | _____ |

Certified Ophthalmic Technician

ALLIED HEALTH PROFESSIONAL STAFF
REQUEST FOR PRIVILEGES
CERTIFIED OPHTHALMIC TECHNICIAN

Requested:

Approved:

OTHER

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby request the authority to provide the patient care services checked above for which I am trained and experienced to perform. I understand that the patient care services requested may differ from those finally approved. I further understand that the completion of this form does not preclude me from requesting additional privileges in the future.

Signature of Applicant

Date

I hereby sponsor above signed applicant while acting under my direction and/or while attending to the needs and concerns of my patients only.

Signature of Sponsoring Physician

Date

Certified Ophthalmic Technician