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

CERTIFIED SURGICAL TECH

______________________________ ______________________________

Applicant's Name (PRINT) Date

Requested: Approved:

ASSIST - UNDER DIRECTION OF SURGEON IN O.R.

Requested	Service	Approved
_____	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	_____

ALLIED HEALTH PROFESSIONAL STAFF
REQUEST FOR PRIVILEGES
CERTIFIED SURGICAL TECH

Requested: Approved:

ASSIST - UNDER DIRECT SUPERVISION OF PHYSICIAN ON NURSING UNITS

_____ Application of traction _____
_____ Apply cast and remove cast _____
_____ Sprains _____
____ Strapping _____
____ Casting _____
____ Splinting _____
_____ Fractures _____
____ Strapping _____
____ Casting _____
____ Splinting _____

Requested: Approved:

MAY PERFORM INDEPENDENTLY AT THE DIRECTION OF PHYSICIAN
WITHOUT DIRECT SUPERVISION

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

ALLIED HEALTH PROFESSIONAL STAFF
REQUEST FOR PRIVILEGES
CERTIFIED SURGICAL TECH

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