

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

**OPERATING ROOM 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<br>to instrument room for reprocessing | _____ |

Operating Room Technician

ALLIED HEALTH PROFESSIONAL STAFF  
REQUEST FOR PRIVILEGES  
OPERATING ROOM TECHNICIAN

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

Operating Room Technician

ALLIED HEALTH PROFESSIONAL STAFF  
REQUEST FOR PRIVILEGES  
OPERATING ROOM 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

Operating Room Technician