



ALLIED HEALTH PROFESSIONAL STAFF  
REQUEST FOR PRIVILEGES  
RN FIRST ASSIST

Requested:

Approved:

ASSIST - UNDER DIRECT SUPERVISION OF PHYSICIAN ON NURSING UNITS

- \_\_\_\_\_ Insertion/removal of drains \_\_\_\_\_
- \_\_\_\_\_ Anterior nasal packing for epistaxis \_\_\_\_\_
- \_\_\_\_\_ Application of traction \_\_\_\_\_
- \_\_\_\_\_ Apply cast and remove cast \_\_\_\_\_
- \_\_\_\_\_ Removal of impacted cerumen \_\_\_\_\_
- \_\_\_\_\_ Sprains \_\_\_\_\_
- \_\_\_\_\_ Strapping \_\_\_\_\_
- \_\_\_\_\_ Casting \_\_\_\_\_
- \_\_\_\_\_ Splinting \_\_\_\_\_
- \_\_\_\_\_ Fractures \_\_\_\_\_
- \_\_\_\_\_ Strapping \_\_\_\_\_
- \_\_\_\_\_ Casting \_\_\_\_\_
- \_\_\_\_\_ Splinting \_\_\_\_\_

Requested:

Approved:

MAY PERFORM INDEPENDENTLY AT THE DIRECTION OF PHYSICIAN  
WITHOUT DIRECT SUPERVISION

- \_\_\_\_\_ Dressing changes \_\_\_\_\_
- \_\_\_\_\_ Transcribe verbal orders from the physician \_\_\_\_\_  
    to be countersigned within 24 hours \_\_\_\_\_
- \_\_\_\_\_ 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 \_\_\_\_\_

RN First Assistant

ALLIED HEALTH PROFESSIONAL STAFF  
REQUEST FOR PRIVILEGES  
RN FIRST ASSIST

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

RN First Assistant