

Loma Linda University Medical Center
 Allied Health Professional
 Nurse Practitioner – Standardized Procedure Request Form

Nurse Practitioner Name: _____

I REQUEST APPROVAL TO PRACTICE UNDER THE FOLLOWING STANDARDIZED PROCEDURE(S)				
(A signed Copy is attached)				
Mark if Requested	SP Number	Standardized Procedure Title	Granted	Deferred

Acknowledgment of AHP

In accordance with the provisions of Section 3055 of the Business and Professions Code, I am licensed as a Registered Nurse and certified in the State of California as a Nurse Practitioner in the State of California and subject to the Laws and the rules and regulations of the California Board of Registered Nursing. I acknowledge that I have received a copy of the Medical Staff Bylaws and Rules and Regulations, and agree to be bound by the terms of the Bylaws and Policies of the Medical Staff and of the hospital and all other manuals and policies relevant to practice privileges at Loma Linda University Medical Center under the AHP category.

I have requested only those Standardized Procedures for which by education, training, current experience and demonstrated performance I am qualified and wish to exercise at Loma Linda University Medical Center, Inc.; **and**

I understand that in exercising any practice privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

 Applicant Signature

 Date

 Print Name

RECOMMENDED BY:

_____ Supervising Physician Signature & Print Name	_____ Date
_____ Service Chief Signature	_____ Date
_____ Interdisciplinary Practice Committee Chair	_____ Date
_____ Credentials Committee Chair	_____ Date
_____ Medical Staff Executive Committee Chair	_____ Date

APPROVED BY:

_____ Governing Board Officer	_____ Date
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