

Loma Linda University Medical Center
 Allied Health Professional Practice Privilege Request Form
 Physician Assistant Working in Head & Neck Surgery

Practitioner Name: _____

Practice Specialty Requested: _____ License # _____

Supervising Physician Name: _____ Specialty: _____

As the Supervising Physician for the above listed Physician Assistant (PA), I hereby request the above listed PA to be permitted to perform and/or assist me as listed below:

Under the responsibility and supervision of the Supervising Physician perform selected diagnostic and therapeutic tasks in each of the four major clinical disciplines (Medicine, Surgery, Orthopedics, Psychiatry). Take a complete, detailed and accurate history; perform a complete physical examination, when appropriate, and record and present pertinent data in a manner meaningful to the Supervising Physician.

An Assistant to the Supervising Physician should have an understanding of the socio-economics of medicine, of the roles of the various health personnel, and of the ethics and laws under which medicine is practiced and governed.

REQUESTED		DISCIPLINE SPECIFIC PRACTICE PRIVILEGES	ACTION		
YES	NO		Approved	Conditions	Defer
Perform and/or assist in the performance of the following laboratory and screening techniques.					
		Laryngoscope fiberoptic			
		Fine needle aspiration of Head and Neck masses			
		Fiberoptic stroboscopy			
		Tuning fork examination			
Perform the following therapeutic procedures.					
		Fiberoptic laryngoscopy			
		Repair simple, Complex lacerations			
		Nasal packing for epistaxis			
		Biopsy mouth, tonsil, oropharynx			
		Nasal debridement			
		Incise and drain abscess of superficial subcutaneous face and neck			
		Cerumen removal			
Assist					
		Assist the Supervising Physician with all Head and Neck Procedures			

Acknowledgment:

In accordance with the provisions of Section 3055 of the Business and Professions Code, I am licensed as a Physician Assistant in the State of California and subject to the Laws and the rules and regulations of the California licensing agency. 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 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 specific practice privileges for which by education, training, current experience and demonstrated performance for which I am qualified and wish to exercise at Loma Linda University Medical Center, Inc.; **and**

I understand that in exercising any clinical 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 _____ Practice Specialty _____

RECOMMENDED BY:

Supervising Physician Signature Print Name Date

Service Chief Signature Date

Credentials Committee Chair Date

Medical Staff Executive Committee Chair Date

APPROVED BY:

Governing Board Officer/Designee Date