

Loma Linda University Medical Center
 Allied Health Professional
 Physician Assistant Practicing within the Family Medicine / Urgent Care Service
 Practice Privilege Request Form
To Be Completed by Supervising Physician

Physician Assistant Name: _____ License # _____

Supervising Physician Name: _____ Specialty: Family Medicine

An Assistant to the Supervising Physician is able to perform, under the responsibility and supervision of the Supervising Physician, selected diagnostic & therapeutic tasks in Family Medicine. This includes taking 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.

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:

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
		Order Radiologic and other studies such as ultrasound, CT and MRI			
		Order blood, urine, wound, bodily fluid exams/testing			
		Perform History & Physical; Develop Assessment & Plan			
		Write specific orders and prescriptions			
		Recognize and evaluate situations which require immediate attention of Physician.			

Perform the following routine therapeutic procedures.

		Subcutaneous and intramuscular injections			
		Simple wound closure and/or debridement of superficial skin infections, suture and care of superficial wounds.			
		Removal of sutures			
		Removal of drains			

Assist the Supervising Physician with the following:

		Facilitate physician's referral of patients to appropriate health facilities and specialists			
		Complete forms pertinent to patient's medical record			
		Instruct and counsel patients regarding physical and mental health, and understanding the long term management of their condition			

Acknowledgment:

In accordance with the provisions of Section 3055 of the Business and Professions Code, the above PA is licensed as a Physician Assistant (PA) in the State of California and subject to the Laws and the rules and regulations of the California licensing agency. I acknowledge that the PA has received a copy of the Medical Staff Bylaws and Rules and Regulations, and that the PA agrees 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 for this PA only those specific practice privileges for which he/she has appropriate education, training, current experience, and demonstrated performance for which he/she is qualified and I wish this PA to exercise at Loma Linda University Medical Center, Inc.; **and**

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

REQUESTED BY:

_____	_____	_____
Supervising Physician Signature	Print Name	Date

Acknowledgement:

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 will perform 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.

ACCEPTED BY:

_____	_____	_____
Physician Assistant Signature	Print Name	Date

RECOMMENDED BY:

_____	_____
Service Chief Signature	Date

_____	_____
Credentials Committee Chair	Date

_____	_____
Medical Staff Executive Committee Chair	Date

APPROVED BY:

_____	_____
Board Officer Signature	Date