

**SAN GORGONIO MEMORIAL HOSPITAL
PRIVILEGE DELINEATION LIST
NURSE PRACTITIONER / FAMILY PRACTICE**

NAME OF APPLICANT: _____ DATE: _____

YEAR OF BOARD CERTIFICATION/RE-CERTIFICATION _____

PRIVILEGES CATEGORY	QUALIFICATIONS/CRITERIA
CATEGORY 1	USUAL AND CUSTOMARY PRIVILEGES (Procedures considered included in minimal formal training.)
	<p>QUALIFICATIONS:</p> <ol style="list-style-type: none"> 1. Current California Registered Nurse and Nurse Practitioner licenses. 2. Current professional liability insurance. 3. Employment agreement with the sponsoring physician. 4. Privileges will be proctored per Medicine Service Rules and Regulations.
CATEGORY 2	ADVANCED PRIVILEGES (Procedures performed requiring special expertise and/or requiring documented special training and/or certification, when it exists or proctoring.)
	<p>QUALIFICATIONS:</p> <ol style="list-style-type: none"> 1. All category I requirements 2. Demonstrate comparable competency to perform the privileges requested based on proctoring reports, reference letters, activity reports or other documentation acceptable to the Medical Service.

San Gorgonio Memorial Hospital
 Family Practice Privilege for Nurse Practitioner Delineation

CATEGORY 1 USUAL AND CUSTOMARY PRIVILEGES	REQUESTED	GRANTED
<p>ASSESSMENT OF PATIENT:</p> <ol style="list-style-type: none"> 1. Perform, interpret and dictate a thorough history and physical on assigned patients. 2. Examine and evaluate patients on a daily and as needed basis. Visits will be documented on the progress notes. 3. Evaluate patient and family needs for teaching and counseling. Collaborate with other members of the health care team regarding teaching needs. 4. Re-evaluate diagnosis as new or additional assessment data becomes available. <p>PLANNING:</p> <ol style="list-style-type: none"> 1. Initiate an individualized plan of care based on medical and nursing diagnosis and appropriate standards of care. 2. Develop short and long term goals with the patient and family. 3. Initiate discharge planning. <p>IMPLEMENTATION:</p> <ol style="list-style-type: none"> 1. Prescribing interventions consistent with the plan of care and consistent with scope of practice. 2. Furnish pharmacologic agents based on standardized procedures. 3. Assist the physician with procedures. 4. Coordinate, with the attending physician, referrals and consultations <p>MANAGEMENT OF DIAGNOSIS:</p> <ol style="list-style-type: none"> 1. Cardiovascular Medicine 2. Dermatology 3. Endocrinology 4. Gastroenterology 5. Hematology/Oncology 6. Infectious Disease 7. Nephrology 8. Neurology 9. Pulmonology 10. Rheumatology 	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
CATEGORY 2 ADVANCED PRIVILEGES (Procedures performed requiring special expertise and/or required documented special training and/or certification, when it exists)	REQUESTED	GRANTED After proctoring
<p>CARDIAC PROCEDURES (ACLS required):</p> <ol style="list-style-type: none"> 1. Cardiopulmonary resuscitation <p>DIAGNOSTIC PROCEDURES:</p> <ol style="list-style-type: none"> 1. Nasogastric/oral gastric tube placement <p>GENITOURINARY PROCEDURES:</p> <ol style="list-style-type: none"> 1. Bladder catheterization/Foley catheter <p>HEMODYNAMIC TECHNIQUES:</p> <ol style="list-style-type: none"> 1. Arterial blood gases <p>MEDICAL PROCEDURES:</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

San Geronio Memorial Hospital
 Family Practice Privilege for Nurse Practitioner Delineation

1. Ablation nail matrix	_____	_____
2. Femoral line placement	_____	_____
3. Paracentesis	_____	_____
4. Joint Aspiration	_____	_____
5. Joint Injection	_____	_____
6. Wound debridement	_____	_____
7. Suture skin	_____	_____
8. Mechanical Ventilation (>24 hours)	_____	_____
9. I & D skin	_____	_____
10.EKG interpretation	_____	_____
ENT PROCEDURES:		
1. Anterior nasal packing	_____	_____
2. Ear exam/removal of foreign body	_____	_____

STAFF CATEGORY REQUESTED: ALLIED HEALTH PROFESSIONAL

SIGNATURE OF APPLICANT: _____ DATE _____

APPROVALS:

Applicant may perform privileges and procedures as indicated: []

Exceptions/Limitations: _____

I have reviewed the applicant's health status and can attest that there are no health problems that exists that could affect his or her ability to perform the privileges requested.

Medical Services Committee Chairman _____
Date

Credentials Committee Chairman _____
Date

Medical Executive Committee Chairman _____
Date

Board of Directors Chairman _____
Date