PRACTICE AREA: PHYSICIAN'S ASSISTANT / ADVANCED REGISTERED NURSE PRACTITIONER – DELINIATION OF CLINICAL ACTIVITIES

To request clinical activities for physician assistant, the following minimum threshold criteria must be met:

1. Certification by the NCCPA, with a current license as a Physician Assistant in the state of Iowa; or
2. Certification by the American Nurses Credentialing Center or the American Academy of Nurse Practitioners, with a current license as an Advanced Registered Nurse Practitioner in the state of Iowa.
3. Current registration with the Federal Drug Enforcement Administration and the Iowa Board of Pharmacy examiners.
4. Employed and sponsored by a medical staff member of Lakeview Surgery Center

PHYSICIAN' ASSISTANT ACTIVITES - I am requesting physician assistant clinical activities:

Requested	Granted	
❒	❒	Conduct histories; develop treatment plans; perform physical exam
❒	❒	Document history and physicals; record progress notes; write discharge summaries
❒	❒	Write orders for medications, treatments, tests, IV fluids, etc.
❒	❒	Provide pre and postoperative surgical care
❒	❒	Assist physician/dentist with gowning, gloving, prepping, and draping
❒	❒	Scrub into the surgical case, maintain sterile technique, pass instruments and provide exposure of operative site by retracting tissue and suctioning as necessary
❒	❒	Assisting with hemostasis
❒	❒	Assist with closure of wound
❒	❒	Maintain comfort and safety of patient during the surgical procedure

All of the above activities will be carried out under the supervision of a physician member of the Medical Staff. I understand that in making this request I am bound by the applicable bylaws or policies of the Lakeview Surgery Center and hereby stipulate that I meet the threshold criteria for each request.

_____ _____

Applicant's Signature Date

_____

Applicant Name (Print)

Acknowledgement of Supervising Physician: The above-named practitioner shall be under my supervision in the exercise of clinical activities. I acknowledge the practitioner is qualified and competent to perform the requested activities.

_____ _____

Supervising Physician Signature Date

_____

Supervising Physician (Print)

Clinical Activities:

Granted _____ Deferred _____ _____

MEC Signature **Date**

Granted _____ Deferred _____ _____

GB Signature **Date**

Modifications: _____