

**GULF COAST MEDICAL CENTER**  
**Delineation of Privileges for Allied Health Professional**  
**Diagnostic & Therapeutics**

Name: \_\_\_\_\_ Physician Sponsor(s)/Contract: \_\_\_\_\_

License Number(s): \_\_\_\_\_ Certification/Re-certification Number: \_\_\_\_\_

Check here if Non-Licensed or Non-Certified

PRIVILEGE	Currently Approved	Requested	Approved
<b>DIAGNOSTICS:</b>			
Electroencephalography			
NCV; EMG (non-invasive)			
Echocardiography			
<b>PERFUSIONIST / CIRCULATION TECHNOLOGIST:</b>			
Operate autotransfusion machine (cell saver)			
Provide pacemaker standby			
<b>CARDIOPULMONARY REHAB – HOSPITAL TEACHING:</b>			
Coronary artery disease			
Myocardial infarctions			
Cardiac catheterizations/angioplastys			
Coronary artery bypass grafts			
Chronic obstructive lung disease			
Bronchitis			
Asthma			
Emphysema			
Thoracotomy/lobectomy			
Purse lip breathing			
Diaphragmatic breathing			
Rhythmic breathing			
Stress management			
Smoking			
Lifestyle			
Exercise			
<b>OTHERS:</b>			
Lithotripsy			
Mental Health Assessments			

Comments / Modifications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

I hereby request that I be allowed to perform the privileges requested, as delineated above that are checked above, under the supervision of my sponsoring physician(s) and attest that I have current competence to perform each of them.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

I/We, the sponsoring physician(s) hereby affirm that this individual is sufficiently competent to perform the privileges requested.

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Signature of Department Chairperson**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Credentials Approval**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Medical Executive Approval**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Board of Trustees Approval**

\_\_\_\_\_  
Date