

**GULF COAST MEDICAL CENTER**  
**Delineation of Privileges for Allied Health Professional**  
**RN First Assistant**

Name: \_\_\_\_\_ Physician Sponsor(s)/Contract: \_\_\_\_\_  
 License Number(s): \_\_\_\_\_ Certification/Re-certification Number: \_\_\_\_\_

PRIVILEGE	Currently Approved	Requested	Approved
<b>GENERAL:</b>			
Assist in Surgery			
Suture minor surgical procedures			
Close incision lines			
Remove sutures/staples			
Incise and drain superficial skin infections			
Change dressings			
Administer local infiltrative anesthetic			
Perform nasogastric intubation			
<b>OTHERS:</b>			

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

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

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 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

Revised 12/02