CERTIFIED REGISTERED NURSE ANESTHETIST
PRIVILEGE FORM

NAME:_____ **EFFECTIVE DATE:**_____ **To**_____

LEGEND: **1 – BMC - Jax** **2 – BMC - Beaches** **3 – BMC - Nassau** **4 – SV Southside** **5 – SV Riverside**
6 – UF Health Jax/ TCU **7 – Wolfson** **8 – Brooks** **9 – BMC - South** **10 – SV Clay**

The minimum education, training and experience qualifications for core privileges are as delineated in each hospital's Medical Staff Bylaws, Rules and Regulations, or policies. Please consult these documents to determine your eligibility to request these privileges.

To request Core Privileges, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	10	CORE PRIVILEGES	APPR
										Initial and ongoing assessment of patient's medical, physical, and psychosocial status, including: conduct history and physical; develop treatment plan; perform rounds; record progress notes; order test, examinations, medications, and therapies; and write discharge summary. These core privileges also include anesthesia management and administration; performing ET or OT intubation; and resuscitative measures. **All privileges are conducted in accordance with an approved written protocol between the CRNA and the sponsoring/responsible physician.**	

To request Special Procedures, please place an "X" in the appropriate hospital column. If the condition/privilege you desire is not included on this form, please submit a separate written request for the privilege along with documentation of training and/or experience.

1	2	3	4	5	6	7	8	9	10	SPECIAL PROCEDURES Procedures that are not routinely part of training, and may require proof of training or experience.	APPR
	■		■	■		■	■		■	Perform an epidural blood patch	
							■			Place peripheral arterial lines	
	■	■	■	■			■		■	Place central venous lines	
	■						■			Initiate epidural anesthesia	
	■						■			Maintain epidural anesthesia	
							■			Initiate and maintain spinal anesthesia **[++Hospitals 4, 5, 10]**	

Acknowledgment of Practitioner: I understand that (a) in exercising clinical privileges granted, I am constrained by each hospital's Medical Staff policies, rules and regulations, and (b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of each hospital's Medical Staff Bylaws.

Applicant Signature: _____ ***Date:*** _____

Acknowledgment of Supervising Physician: The above named practitioner shall be under a departmental anesthesiologist's supervision in the exercise of clinical privileges. I acknowledge that above named practitioner is competent and qualified to perform the requested privileges.

Supervising Physician Signature:_____ ***Date:*** _____

Supervising Physician Printed Name*:* _____

Supervising Physician Signature:_____ ***Date:*** _____

Supervising Physician Printed Name: _____

■ Privilege not available in this specialty at this hospital.

++ Please refer to this hospital's Bylaws or Rules and Regulations regarding specific criteria to be met before this privilege may be granted.