

Clinical Research Coordinator

PRIVILEGE FORM

NAME: _____ **EFFECTIVE DATE:** _____ to _____

-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.

LEGEND: 1- Baptist 2- Beaches 3- Nassau 4- St. Luke's 5- St. Vincent's
 6- Shands/Jax 7- Wolfson 8- Brooks 9- South

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

1	2	3	4	5	6	7	8	9	CORE PRIVILEGES	APPR
									Patient history and physical exam	
									Administer medication including IV fluids & oral meds.	
									Venipuncture	
									Hemodynamic and ECG monitoring	
									Write verbal orders	
									Obtain informed consent for patients to participate in clinical trial	
									Collect stool/urine specimens.	
									Patient education	
									Perform ECGs	

O Privilege not available in this specialty at this hospital.

Acknowledgement 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:** _____

Acknowledgement of Supervising Physician: The above-named practitioner shall be under my direct supervision in the exercise of clinical privileges. I acknowledge the above-named practitioner is competent and qualified to perform the requested privileges. **It is understood that any medical record entries (i.e. recording removal of sutures or dressing changes) by this practitioner will be countersigned by me within twenty-four (24) hours.**

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

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

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