INTRAOPERATIVE MONITORING TECHNOLOGIST

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 – BMC - Jax** **2 – BMC - Beaches** **3 – BMC - Nassau** **4 – SV Southside** **5 – SV Riverside** **6 – Shands Jax/SJ TCU** **7 – Wolfson** **8 – Brooks** **9 – BMC - South** **10 – SV Clay**

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

1	2	3	4	5	6	7	8	9	10	INTRAOPERATIVE MONITOR CORE PRIVILEGES	APPR
	■	■					■			Lumbar Spine Surgeries	
	■	■					■			Thoracic Spine Surgeries	
	■	■					■			Cervical Spine Surgeries	

To request Special Procedures, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	10	ADVANCED OPERATIVE CASES .	APPR
	■	■					■			Complex Scoliosis Surgery	
	■	■					■			Craniotomy for Tumor Resection	
	■	■					■			Craniotomy for Vascular Surgery	
	■	■					■			Large Joint Surgery with Peripheral Nerve protection	
										MODALITIES	
	■	■					■			Intraoperative EEG	
	■	■					■			Intraoperative EMG	
	■	■					■			Triggered EMG and Pedicle Screw Testing	
	■	■					■			Somatosensory Evoked Potentials	
	■	■					■			Tran Cranial Electrical Motor Evoked Potentials	
										INTERMEDIATE TECHNIQUES	
	■	■					■			Auditory Evoked Potentials	
	■	■					■			Cortical Mapping for Motor Strip Identification	

■**Privilege not available in this specialty at this hospital. ++ Please refer to hospital's specific criteria to be met before this privilege may be granted.**

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:*** _____

INTRAOPERATIVE MONITORING TECHNOLOGIST

PRIVILEGE FORM

NAME: _____ EFFECTIVE DATE: _____ to _____

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

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

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

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

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

Edition Date: 5/28/2013 – SVMC