

PERFUSION ASSISTANT PRIVILEGE FORM

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

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

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 privileges, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	10	PRIVILEGES	APPR
										Intra-operative autologous blood recovery (cell saver and/or orthopat, cardiopat)	
										Post-operative autologous blood recovery (cell saver and/or orthopat, cardiopat)	
										Patient transport	
										Equipment cleaning and disposal of used circuits	
										Stocking and inventory management	

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:** _____

Acknowledgment of Supervising Physician: The above named practitioner shall be under my supervision (direct or indirect in accordance with the laws of the State of Florida) in the exercise of clinical privileges. I acknowledge that 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:** _____

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