RN

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	RN or LPN CORE PRIVILEGES	APPR
		■			■				May accompany supervising physician on patient rounds **[++Hospital 2]**	
		■			■				**RN Only:** May record verbal orders for consults, diagnostic tests, nutrition, or medications **[++Hospital 2]**	
		■			■				Provide patient education (i.e: homecare, discharge instructions) **[++Hospital 2]**	

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

1	2	3	4	5	6	7	8	9	SPECIAL PROCEDURES (RN ONLY) Procedures that are not routinely part of training, and may require proof of training or experience.	APPR
		■			■				Obtain informed consent for patients to participate in clinical trial	
■	■	■			■	■	■	■	Cardiac stress testing (supervision only) **[++Hospital 6, 7]**	
		■			■				Removal of chest tubes **[++Hospital 2, 6, 7]**	
		■			■				Administer medication including IV fluids & oral medications [per FL Nurse Practice Act – FL Statutes 434.003]	
		■			■				Obtain patient history for review by supervising physician	
		■			■				Urinary catheterization	
		■			■				Remove casts	
		■			■				Remove sutures or staples	

O 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:*** _____

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:*** _____