Texas Health Presbyterian Hospital ROCKWALL
Healing Hands. Caring Hearts.

Orthotics and Prosthetics Request for Delineation of Privileges

NAME:_____

LICENSURE: Current Orthotist/Prosthetist licensure issued by the Texas Department of State Health Services. Current certification from the American Board for Certifiation in Orthotics and Prosthetics (ABC) and the Board for Orthotist/Prosthetist Certification (BOC) as an Certified Orthotist (CO), Certified Prosthetist (CP), or Certified Prosthetist-Orthotist (CPO).

DEFINITION: An orthotics practitioner providers or manages the provision of an external orthopedic applicance such as a brace or a splint that prevents or assists movement of the spine or the limbs. A prosthetic practitioner provides or manages that provision of an artificial substitute for a missing body part such as an arm or leg that is used for functional or cosmetic reasons or both.

SCOPE OF PRACTICE: The Orthotist/Prosthetist may provide only those services for which he or she is specifically authorized.

SUPERVISION: The orthopedic surgeon supervises the Orthotist/Prosthetist's activities.

PRESCRIPTIVE AUTHORITY: None

RESPONSIBILITY: An orthotist/prosthetist is the pratitor who is trained to custom make and fir both orthoses and prostheses. These functions are based on a clinical assessment and a physicans prescription to restore physiological function and/or cosmesis.

Regulations do not authorize the exercise of independent medical judgment by an Orthotist/Prosthetist. The supervising \ sponsoring physician(s) remain responsible and liable to the patients for acts performed under the physician's delegated authority. Orthotists/Prosthetists remain professionally responsible for acts performed under the scope and authority of their own licensure.

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I, _____, hereby request privileges in the specialty of **ORTHOTICS/PROSTHETICS**. I further understand that privileges requested may differ from those approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

(Please check privileges desired)

R = REQUESTING FULL PRIVILEGE
N = NOT REQUESTED

(R)	(N)		**ORTHOTICS/PROSTEHTICS**
____	____	00001	Review medical records and examin patients to evaluate functional loss and O&P needs
____	____	00002	Formulate O&P patient prescriptions for optimal management of upper and lower limb anomalies, both congenital and acquired, in collaboration with physicians
____	____	00003	Supervise the fabrication of O&P devices and applicants to ensure that design and materials meet patient needs
____	____	00004	Fit and adjust devices and applicaces on patients to ensure optimum function, cosmesis and workmanship
____	____	00005	Instruct patients on the limitations and proper use of devices and applicances as well as the maintenance, storing, and cleaning of devices and applicances
____	____	00006	Enter clinical and evaluation notes in patient medical records
____	____	00007	Conduct O&P clinics and participate in orthopedic clinic lectures

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NAME:_____

SPONSORING PHYSICIAN:
I certify that the named assistant is competent to perform all delineated privileges as indicated above and I accept full responsibility for the actions of this assistant while in the performance of the privileges requested.

_____ _____/_____/_____
Signature of Sponsoring Physician Date

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at **Presbyterian Hospital of Rockwall**, and

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

_____ _____ _____/_____/_____
(Applicant Name – Print) (Signature) Date

DEPARTMENT CHAIRMAN RECOMMENDATION

I have reviewed the requested clinical privileges, as well as the appointment / reappointment application, performance improvement profile, and other pertinent appointment / reappointment information. Based on my review I propose the following:

☐ Recommend ☐ Recommend with Modifications ☐ Not Recommended ☐ Deferred for Committee Discussion

Comments: _____

_____

_____

_____ _____/_____/_____
Department Chairman Signature Date

_____ _____/_____/_____
President of Medical Staff Date

_____ _____/_____/_____
Presbyterian Hospital of Rockwall Administration (if applicable) Date