Texas Health Presbyterian Hospital ROCKWALL
Healing Hands. Caring Hearts.

Licensed Surgical Assistant Request for Delineation of Privileges

NAME:_____

LICENSURE: Current licensure licensure issued by the Texas Medical Board and must follow all guidelines, rules, and regulations established by the Texas Medical Board for Surgical Assistants.

DEFINITION: The Licensed Surgical Assistant (LSA) may perform medical functions only in the fields for which he/she has been trained, approved, and registered and will be re-evaluated for reappointment every two (2) years. The Licensed Surgical Assistant provides aid under direct supervision in exposure, hemostasis, and other intraoperative technical functions that assist a physician in performing a safe operation with optimal results for the patient, including the delegated authority to provide local infiltration or the topical application of a local anesthetic at the operation site.

SCOPE OF PRACTICE: The Licensed Surgical Assistant (LSA) may provide only those services for which he or she is specifically authorized.

SUPERVISION: A Surgeon (MD, DO, DPM) supervises the LSA's activities. Supervision shall be continuous, and shall require that the delegating physician be physically present and immediately available in the operating room to personally respond to any emergency until the patient is released from the operating room and care has been transferred to another physician. Telecommunication is insufficient for supervision purposes.

PRESCRIPTIVE AUTHORITY: None

RESPONSIBILITY: Regulations do not authorize the exercise of independent medical judgment by an LSA. The supervising \ sponsoring physician(s) remain responsible and liable to the patients for acts performed under the physician's delegated authority. LSA's 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 **LICENSED SURGICAL ASSISTANT.** 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)		**Licensed Surgical Assistant**
____	____	00001	Determining specific equipment needed for procedure
____	____	00002	Reviewing permit to confirm procedure and special needs
____	____	00003	Selecting and placement of x-rays for reference
____	____	00004	Assisting in moving and positioning the patient
____	____	00005	Inserting and removal of Foley urinary bladder catheter
____	____	00006	Placing the pneumatic tourniquet
____	____	00007	Confirming procedure with surgeon
____	____	00008	Draping the patient within the surgeon's guidelines
____	____	00009	Providing retraction of tissue and organs for optimal visualization with regard to tissue type and appropriate retraction instrument or technique
____	____	00010	Assisting in maintaining hemostasis by direct pressure, using and applying surgical instrument for the task, placement of ties, placement of ligatures, applying chemical hemostatic agents, or other measures as directed by the surgeon
____	____	00011	Using the electrocautery mono and bi-polar
____	____	00012	Clamping, ligation and cutting of tissue per surgeon's directive
____	____	00013	Harvesting saphenous vein including skin incision per surgeon's directive
____	____	00014	Dissecting of common femoral artery and bifurcation per surgeon's directive
____	____	00015	Maintaining integrity of sterile field
____	____	00016	Closing of all wound layers (fascia, subcutaneous and skin) as per surgeon's directive
____	____	00017	Inserting drainage tubes per surgeon's directive
____	____	00018	Selecting and applying wound dressing

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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