DETROIT MEDICAL CENTER
CERTIFIED NURSE PRACTITIONER
REQUEST FOR PRIVILEGES

ADVANCED PRACTICE NURSE _____

SPONSORING PHYSICIAN _____

SPECIALTY AREA _____

CLIENT POPULATION: _____ Neonate _____ Pediatric _____ Adult

CRITERIA: TO BE ELIGIBLE FOR PRIVILEGES, THE CERTIFIED NURSE PRACTITIONER MUST EITHER BE EMPLOYED BY THE DETROIT MEDICAL CENTER OR EMPLOYED BY A PHYSICIAN WHO IS CURRENTLY ON THE MEDICAL STAFF OF THE DETROIT MEDICAL CENTER.

The functions identified below do not include all areas of responsibility. Identified are those activities which are done in collaboration with a physician.

Approval to perform the following functions is requested:

_____ Perform history and physical exams

_____ Order and monitor diets and diagnostic tests, i.e. lab tests, x-rays, etc.

_____ Order non-controlled medications and non-pharmacologic therapies

_____ Order IV fluids, blood and blood products

_____ Order interdisciplinary consults

_____ Documentation of treatment plan, i.e. progress notes, discharge summary, clinic record, etc.

_____ Provide phone consultation

_____ Act as assistant in surgical procedures as approved by the respective department

_____ Ordering of restraints **(evidence of completion of HealthStream/Net Learning module required)**

_____ Obstetrical privileges per addendum

_____ Performs other medical procedures for which applicant has demonstrated competence, according to policy **(specify and complete attached Procedure Certification form):**

_____

_____

_____

_____

_____

_____

_____ Additional functions **(specify)**:

_____

_____

_____ _____

Signature of Certified Nurse Practitioner Date

I hereby acknowledge that I recommend this individual for the privileges requested. He/she will be under my direction and I assume full responsibility for his/her actions with respect to his/her patients at The Detroit Medical Center.

_____ _____

Signature of Sponsoring Physician Date

_____ _____

Signature of Specialist-in-Chief Date

Approved: Joint Conference Committee _____

OBSTETRICAL ADDENDUM

Identified below are those obstetrical activities which are done, utilizing applicable guidelines, in collaboration with a physician and for which applicant has demonstrated competence according to policy as documented on the following page.

Approval to perform the following functions is requested.

_____ Local Anesthesia

_____ Order controlled substances during labor

_____ Complete management of the normally progressing labor and delivery with attending supervision

_____ Repair vaginal laceration under attending supervision

_____ Perform amnioinfusion

_____ Basic ultrasound

_____ Newborn circumcision

_____ Performance of biophysical profile

_____ Interpretation of fetal heart rate monitoring including internal and external methods
Criteria: Documentation of completion of Detroit Medical Center-designated fetal monitoring course at a minimum of every two years.

_____ Application of fetal monitoring including fetal scalp lead and intrauterine pressure catheter

_____ _____
Signature of Certified Nurse Practitioner Date

I hereby acknowledge that I recommend this individual for the privileges requested. He/she will be under my direction and I assume full responsibility for his/her actions with respect to his/her patients at The Detroit Medical Center.

_____ _____
Signature of Sponsoring Physician Date

_____ _____
Signature of Specialist-in-Chief Date

DETROIT MEDICAL CENTER
PROCEDURE CERTIFICATION

Name ____

☐ Advanced Practice Nurse ☐ Physician Assistant

Sponsoring Physician ____________________________________

PROCEDURE ____

DIDACTIC METHOD ______________________________ Date__________
(readings, classroom as per policy)

PRACTICAL DEMONSTRATION OF PROCEDURE ________________________
DATE APPROVED

CERTIFYING PHYSICIAN __________________________ Date__________
(signature of physician or designated professional checking performance of procedure)

PROCEDURE ____

DIDACTIC METHOD ______________________________ Date__________
(readings, classroom as per policy)

PRACTICAL DEMONSTRATION OF PROCEDURE ________________________
DATE APPROVED

CERTIFYING PHYSICIAN __________________________ Date__________
(signature of physician or designated professional checking performance of procedure)

PROCEDURE ____

DIDACTIC METHOD ______________________________ Date__________
(readings, classroom as per policy)

PRACTICAL DEMONSTRATION OF PROCEDURE ________________________
DATE APPROVED

CERTIFYING PHYSICIAN __________________________ Date__________
(signature of physician or designated professional checking performance of procedure)

PROCEDURE ____

DIDACTIC METHOD ______________________________ Date__________
(readings, classroom as per policy)

PRACTICAL DEMONSTRATION OF PROCEDURE ________________________
DATE APPROVED

CERTIFYING PHYSICIAN __________________________ Date__________
(signature of physician or designated professional checking performance of procedure)

Approved Joint Conference Committee, 3/23/99