Regions Hospital
Delineation of Privileges
Surgical (Surgeons) Assistant

Applicant's Name:_____ _____

Last **First** **M** **Date**

Instructions: **Applicants must provide complete names and addresses for their references. <u>Please DO NOT SEND letters of recommendation along with your application</u>. These must be primary source verified by Regions Hospital. If documentation of cases or procedures is required, please attach case and/or procedural logs to your privilege delineation.**

☐ **CORE I- General Privileges Surgical Assistant**

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
A Surgical Assistant (SA) is one who assists the surgeon in the performance of any surgical procedure, working under the surgeon's direction. Surgical Assistant's act as a first or second assistant to the surgeon, they have extensive knowledge of anatomy and physiology; assists the surgeon in draping of the patient, retracts tissue and exposes operating field area during operative procedures, clamps and ties vessels to control bleeding during surgical entry, keeps the operative site dry, affords the surgeon the best possible exposure of the anatomy incident to the operation, assists the surgeon in identifying any structure which should not be ligated and keeps these structures from operative site by retraction, in prepared to anticipate the moves of the surgeon, is knowledgeable in all surgical procedures sufficient enough to assist the surgeon in any way, knows instruments used in any procedure, and assists in closure of the incision including tying off the bleeders, applying sutures and wound dressings and performs any and all tasks required by the surgeon, incident to the particular surgical procedure.	1. Candidate Member, or 2. Certification by the National Surgical Assistant Association or other appropriate surgical assistant organization, or 3. Appropriate training or experience that supervising physician agrees is appropriate.	<u>New Applicants:</u> 1. Name and address of a surgeon who the applicant has worked with recently, **and** a surgeon's assistant who the applicant has worked with recently whom we may contact who can attest to the competency to perform the requested privileges. _____ _____ _____ <u>Reappointment Applicants:</u> 1. Evaluation of your competency conducted by a peer of your choice. Please indicate name and address of the individual whom we may contact. _____ _____ _____

TO BE COMPLETED BY APPLICANT:

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges will not proceed until which time that the information is received.

_____ _____

Signature Date

TO BE COMPLETED BY SPONSORING PHYSICIAN:

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

_____ _____

Sponsoring Physicians Signature Date

TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL:

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

_____ _____

Regions Division/Section Head Signature Date