Certified Surgical Assistant/ Surgical First Assist

SCOPE OF PRACTICE

Name: _________________________________________________

please print

CRITERIA TO APPLY FOR PRIVILEGES

<table>
<thead>
<tr>
<th>Minimum Formal Training</th>
<th>Completion of a specialized course of studies which includes didactic and supervised clinical learning activities, as outline by the AST or AORN. *Surgical Assistants/ First assistants privileged prior to 2/1/2010 are exempt from these criteria if not certified.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certifications</td>
<td>New Applicant: Current CST/CFA/CNOR certification*; Current State of Colorado registration; Current Red Cross or American Heart Association BLS Certification that includes a skills lab</td>
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<tr>
<td></td>
<td>*Surgical Assistants/ First assistants privileged prior to 2/1/2010 are exempt from these criteria if not certified.</td>
</tr>
<tr>
<td></td>
<td>Reappointment: Maintenance of certifications and registration is required. Failure to maintain certification/licensure will result in automatic relinquishment of privileges.</td>
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<tr>
<td></td>
<td>Current Red Cross or American Heart Association BLS Certification that includes a skills lab</td>
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<tr>
<td>Supervision</td>
<td>Employment by or an agreement with a physician currently appointed to the BCH medical staff to supervise the SA/RNFA’s practice in the hospital. See attached sponsoring physician statement.</td>
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<tr>
<td>Additional Criteria</td>
<td>Relevant Continuing Medical Education.</td>
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</tbody>
</table>

SCOPE OF SERVICES – CORE

- Safe positioning of the surgical patient
- Collaborates in the verification and preparation process of the appropriate surgical site
- Establish and maintain sterile field
- Applies electrosurgical grounding pads, tourniquets, monitors, etc., before procedure begins
- Prepares the patient’s skin prior to draping by the surgical team
- Pass needed instruments, sutures, supplies and other equipment
- Provide hemostasis by coagulating bleeding points
- Provide exposure through appropriate use of instruments, retractors, suctioning, and sponging techniques
- Agrees to follow departmental/hospital applicable policies/procedures including all surgical required counts
- Tie sutures
- Subcutaneous closure
- Skin closure
- Secures dressings after incision closure

ADDITIONAL REQUESTS UNDER DIRECT SUPERVISION

<table>
<thead>
<tr>
<th>Request</th>
<th>Procedure</th>
<th>Credentialing Criteria Initial / Reappointment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Autologous Graft Preparation</td>
<td>Initial: Documentation of specific training during the applicant’s training program with documentation of a combination of 20 surgical assists included in training or completed within the past 12 months. Proctoring for first 5 if numbers criteria not met. Reappointment: documentation of a combination of 10 surgical assists completed within the past 24 months.</td>
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<tr>
<td></td>
<td>Preparation of Implantation Tissue</td>
<td>Additional training or experience that demonstrates current competence in surgically assisting in laparoscopic procedures. and Successful completion of BCH training course or Documentation of robotic assisting experience (provide a log) and successful completion of the robotic first assistant skills assessment checklist</td>
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<tr>
<td></td>
<td>Robotic Assisted Surgical Assist (da Vinci only)</td>
<td>Note: Proctoring of at least the first 2 cases may be required based on the level of past. The proctor may not be the principle surgeon.</td>
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<td></td>
<td>Robotic Assisted Surgical assists- Trocar insertion, following initial placement by surgeon. Under direct supervision of the surgeon</td>
<td>Additional training or experience that demonstrates current competence in surgically assisting in laparoscopic procedures. and Robotic surgical assist privileges</td>
</tr>
</tbody>
</table>

I hereby request the above listed privileges. I am requesting privileges and procedures commensurate with my training and/or experience.

Applicant Signature: ____________________________ Date: ________________

Please Sign Your Name

Applicant Name: ____________________________________________

I am a collaborative or backup Medical Staff Member of the individual named above. I understand and agree that the Boulder Community Health and Medical Staff Bylaws, and associated documents, require that I accept the responsibilities as outlined in the collaborative or backup agreements with respect to this individual while performing specified procedures.

Further, I understand that, in the event this individual’s association with me is terminated, or I otherwise withdraw my agreement to maintain a current collaborative or backup agreement with the AHP, I will provide prompt, written notice of such termination to the Medical Staff Department. Additionally, the hospital may, at any time, affect the AHP’s Scope of Practice, if my medical staff membership or privileges are suspended or terminated.

SIGNATURE(s) OF ALL COLLABORATING PHYSICIAN(s)

Medical Staff Member ____________________________________________

Medical Staff Member ____________________________________________

Medical Staff Member ____________________________________________

Medical Staff Member ____________________________________________

Medical Staff Member ____________________________________________

Medical Staff Member ____________________________________________

Medical Staff Member ____________________________________________

Medical Staff Member ____________________________________________

Medical Staff Member’s Name – Printed ________________________________

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