UNIVERSITY OF MARYLAND MEDICAL CENTER
Specified Services for
Physician Assistants

This form should accompany your State Approved Physician Assistant Delegation Agreement and should coincide with what has been approved by the State

Name: _____ **Date:** _____

Department: _____ **Section:** _____

Area of Certification: _____ **Certification Date:** _____

Certifying Organization: _____

State Approved Delegation Agreement on File: _____ **(to be completed by Medical Staff Services)**

Specified Services	**Check if Requested**	**Chair Approval Initial if Yes Write Not Approved if No**
Core Duties		
Conduct histories and physicals		
Interpret and evaluate patient data		
Issue diagnostic orders		
Repair lacerations		
Incision & Drainage of abscess		
Apply splints		
Record patient progress		
Provide instruction and guidance regarding medical matters to patients		
Order laboratory test, x-rays, and special tests and dressing changes		
Prescriptive Authority		
Controlled Dangerous Substances		
Prescriptive Drugs		
Medical Devices		
Others:		
Advanced Duties		
Arterial line insertion		
Thoracentesis		
Lumbar puncture		
Endometrial biopsy		
Stress testing		
Venous cutdown		
Harvesting saphenous veins		
Nasal fiberoptic endoscopy		
Central line insertion		
Others:		

Name: _____ **Date:** _____

Specified Services	**Check if Requested**	**Chair Approval** **Initial if Yes** **Write Not Approved if No**
Moderate (Conscious) Sedation – Individuals prescribing or administering controlled substance analgesics or sedatives during procedures must request this privilege Criteria for Approval 1. Proof of Current BLS certification (please attach) 2. Completion of basic airway management in-service every two years (required for reappointment) 3. Attendance of Department of Anesthesia education seminar required 4. Possession of valid Federal DEA and Maryland Controlled Substance Registrations.		

_____ _____
Applicant's Signature **Date**

_____ _____
Supervising Physician's Name & Signature **Date**

_____ _____
Division Chief's Signature **Date**

_____ _____
Department Chairman's Signature **Date**

_____ _____
Applicant's Confirming Signature **Date**
(required if any requested service is not approved)