

THE NEW YORK EYE AND EAR INFIRMARY
DELINEATION OF PRIVILEGES
DEPARTMENT OF ANESTHESIA
CERTIFIED REGISTERED PHYSICIAN ASSISTANT

NAME: _____

(Please Print)

Instruction:

Applicant: Please put a tick (✓) in the Privilege Requested Column

Chairman/Director: Please put a tick (✓) in the appropriate column

	Privilege Requested	<u>Director of Services</u> Privilege Denied	Privilege Approved
Perform history and physical examinations during pre-admission testing.		_____	_____
Perform post anesthesia evaluations on patients.		_____	_____

SIGNATURE: _____ **DATE:** _____

This is to certify that I have reviews the above named individuals's education's, training and demonstrated skills and have approved the following delineation of functions.

APPROVED: _____ **DATE:** _____

Jonathan Ascher, M.D., Director Anesthesiology