



Memorial Health System

We Hear. We Heal. We Care.

www.memorialhealthsystem.com

1400 East Boulder Street

Colorado Springs, CO 80909

ADVANCED NURSING PRACTICE STUDENT TEMPORARY PRIVILEGES

The following applicant is requesting Temporary Privileges from _____ to _____
(start date) (end date)

This request is based on the following:

The Nursing Support Services has reviewed the student's application file and has identified no issues that would preclude granting this request.

Student Name: _____

Requested Department Assignment: _____

Privileges Requested: Evaluation of patients within area of expertise and the treatment and rendering of therapy to patients; write orders and progress notes under the direct supervision of your sponsoring physician/APN.

<small>FOR DEPARTMENT USE ONLY</small>	
<input type="checkbox"/> Approve as requested	<input type="checkbox"/> Forward student info to credentialing
<input type="checkbox"/> Approve as modified: _____	
<input type="checkbox"/> Do not approve request for the following reason(s): _____	

_____	_____
Director of Nursing Support Services	Date

REQUIREMENTS CHECKLIST

- | | |
|---|--|
| <input type="checkbox"/> PPD | <input type="checkbox"/> Physician Responsibility Agreement Signed |
| <input type="checkbox"/> Current Insurance | <input type="checkbox"/> Copy of Drivers License |
| <input type="checkbox"/> HIPPA Form Signed | <input type="checkbox"/> CACTUS updated to Temporary with Dates |
| <input type="checkbox"/> Confidentiality Agreement Signed | <input type="checkbox"/> Colorado License |
| <input type="checkbox"/> Letter of Good Standing with School | <input type="checkbox"/> BLS/ACLS |
| <input type="checkbox"/> Program Learning Objectives & Curriculum | <input type="checkbox"/> Name Badge Request Form |

Please return to Nursing Education once completed by Preceptor



January 8, 2008

Nursing Support Services
Memorial Health System
1400 East Boulder Street
Colorado Springs, CO 80909

To Whom It May Concern:

I hereby accept responsibility for the supervision of the following Advanced Nursing Practice Student while he/she is on an approved rotation at Memorial Health System for the dates specified below:

Name:
Student Status:
Institution:
Dates (start/end):

Please contact me if there are any questions.

Sincerely, (Please Sign, Date and Print Below)

DATE

PRINTED NAME

CONTACT INFORMATION