Huntington Memorial Hospital

Delineation Of Privileges
Clinical Research Coordinator

Provider Name:

Privilege	Requested	Deferred	Approved
1. Organize and aid with clinical studies.	___	___	___
2. Ensure compliance with study proctocols.	___	___	___
3. Maintain computerized databases for patient demographic and clinical research data.	___	___	___
4. Assist with patient recruitment.	___	___	___
5. Obtain and record data from patients enrolled in IRB approved studies/clinical trails. (Not to remove any part of the patient record, copied or original from the Facility).	___	___	___
6. Maintain and complete source documents and case report forms.	___	___	___
7. Meet with Clinical Research Associate and Clinical Research Monitors regarding case reports, ongoing and upcoming trails.	___	___	___
8. Prepare correspondence, reports, memoranda, etc.	___	___	___
9. Serve as a resource for physicians, nurses, and other members of the health care team with regard to protocol related requirements.	___	___	___
10. Comply with all State and Federal Regulatory Requirements and Hospital Policy's.	___	___	___
11. All data collection and data base maintance must remain current with future HIPPA Regulations.	___	___	___

SUPPLEMENTAL PRIVILEGES:

Phlebotomy Privileges *Criteria*: Requires successful completion of the hospital-based phlebotomy training.	___	___	___

ACKNOWLEDGEMENT OF THE ALLIED HEALTH PROFESSIONAL:

I have requested only those privileges for which I am qualified to perform, based upon my education, training, current experience and demonstrated performance. I understand that in exercising my practice privielges granted, I am constrained by hospital and medical staff policies and rules, including those outlined in the Allied Health Professional Rules and Regulations.

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Clinical Research Coordinator

Provider Name:

Privilege	Requested	Deferred	Approved

Signature of AHP: _____ Date: _____

Signature of Supervising Physician:_____ Date: _____

INTERDISCIPLINARY PRACTICE COMMITTEE RECOMMENDATION:

I have reviewed the requested practice privileges and supportive documentation for the above names applicant and recommend action on the privileges as noted above.

Applicant may perform practice privileges as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

_____

APPROVALS

Interdisciplinary Practice Committee: _____ Date: _____

Medical Executive Committee Date: _____

Board of Directors Date: _____