



ALABAMA STATE BOARD OF MEDICAL EXAMINERS
Insertion of Non-Tunneled Central Venous Line Less than 14F

Additional Certification for Femoral w/ US guidance

CRNP or PA Name: _____ License Number: _____

Collaborating or supervising physician must certify that the initial requirements have been met as follows:

I am requesting to train the above-named advanced level practitioner to perform insertion of non-tunneled central venous line insertion (less than 14F), including the required number of supervised procedures and specified requirements:

_____ **Femoral w/ US guidance (min 5)**

*Two (2) procedures may be performed in simulation lab

_____ Didactic training which includes proper technique of the procedure, use of ultrasound guidance, and sterile technique is required

_____ The APN holds appropriate specialty certification (attach certificate) – limited to ACNP/AGACNP

_____ Appropriate hospital setting to be used to mitigate possible complications of the procedure. Protocol outlines plan for appropriate hospital setting including statement of Trauma Center status (Level 3 contingent on plan for specialty physician being onsite and immediately available)

_____ All procedures performed, including procedures performed during the training period, should be recorded in electronic health record for tracking of frequency of the procedure performance and for complication occurrence.

_____ Ongoing proficiency of five (5) procedures should be performed and documented for annual maintenance. Annual maintenance procedures may be performed in the simulation lab.

_____ Collaborating and supervising physician must be hospital credentialed, actively engaged in the practice of non-tunneled central venous line insertion, and therefore perform non-tunneled central venous line insertion on a routine basis.

_____ I, the collaborating/supervising physician certify that I have read and understand the requirements and that the above criterion has been met by the facility and the advanced level practitioner.

Physician Name _____ Signature _____ Date _____

PA/CRNP Name _____ Signature _____ Date _____

******Training should be representative of the appropriately sized catheter that is anticipated to be utilized by the physician assistant or nurse practitioner.***

Revised 12/15/2022