



ALABAMA STATE BOARD OF MEDICAL EXAMINERS

Insertion of Non-Tunneled Central Venous Line Less than 14F

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:

\_\_\_\_\_ **Internal Jugular w/ US guidance (min 25)**

\*Ten (10) 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

\_\_\_\_\_ CRNP or PA has observed and documented a minimum of ten (10) procedures for the requested skill prior to submitting request to train

\_\_\_\_\_ 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 fifteen (15) procedures should be performed and documented for annual maintenance.

\_\_\_\_\_ 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 Printed Name

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

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