Delineation of Scope of Services & Qualifications - Tier 2

DHP Name: ___________________________

*Healthcare Industry Representatives (HCIR’s) are not permitted to provide hands on care to any patients.*

Instructions:
For purposes of this request, the term “product” refers to any device, equipment, medical system, drug or any other FDA-regulated product which you are promoting, selling, providing training or services as described below. Upload to your eDHP account. Access to facilities shall not be permitted until you are notified of the individual facility approvals.

<table>
<thead>
<tr>
<th>Tier 2</th>
<th>Description</th>
</tr>
</thead>
</table>
|        | I request to provide services that require access to a patient care area. The services I provide may have indirect impact on patients and/or hands-on care which will require supervision from a member of the clinical staff of the facility (i.e. CNO/CNO Designee) during any service at the facility. Services I am requesting to provide include the following (Check all that are being requested):
  | □ Deliver a product to a patient care setting (i.e. nursing care unit)
  | □ Repair or maintain a product
  | □ Provide user training and product support
  | □ Provide clinical assessment/care in a patient care setting
  | □ Please list additional duties: ___________________________

As a DHP I am requesting approval to provide services in the following patient care area(s):
(Check all that are being requested)

□ Cath Lab
□ Endoscopy Lab
□ ER
□ Materials Management
□ Nursing Stations (ICU, NSY, Med Surg)
□ Operating Room

□ Pharmacy
□ Radiology Department
□ Respiratory
□ Sterile Supply
□ Other: ___________________________

DHP Signature: ___________________________ Date: ___________________________

DHP Company/Vendor: ___________________________
**Delineation of Scope of Services & Qualifications - Tier 3**

**DHP Name:** ____________________________

*Healthcare Industry Representatives (HCIR’s) are not permitted to provide hands on care to any patients.*

**Instructions:**
For purposes of this request, the term “product” refers to any device, equipment, medical system, drug or any other FDA-regulated product which you are promoting, selling, providing training or services as described below. Upload to your eDHP account. **Access to facilities shall not be permitted until you are notified of the individual facility approvals.**

<table>
<thead>
<tr>
<th>Tier 3</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I request to provide services that require access to a patient care area. I will provide clinical services and/or direct hands-on care which will require the involvement and supervision of a physician or other licensed independent practitioner (LIP). Services I am requesting to provide include the following (Check all that are being requested):</td>
</tr>
<tr>
<td></td>
<td>□ Deliver a product to a procedural area (i.e. OR, Cath Lab)</td>
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<tr>
<td></td>
<td>□ Demonstrate product usage on a patient</td>
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<tr>
<td></td>
<td>□ Provide technical training to clinicians regarding the product</td>
</tr>
<tr>
<td></td>
<td>□ Assist with clinical care regarding product use or set-up including calibration or performing as the primary use of the product in the care of a patient</td>
</tr>
<tr>
<td></td>
<td>□ Assist with clinical care in a procedural/patient care area (i.e. OR, Cath Lab)</td>
</tr>
<tr>
<td></td>
<td>□ Please list additional duties:</td>
</tr>
</tbody>
</table>

Specify the device(s), equipment, or systems to be used in the provision of services:

Specify the operative or invasive procedure(s) involved in the provision of services:

**As a DHP I am requesting approval to provide services in the following patient care area(s):**

*(Check all that are being requested)*

- □ Cath Lab
- □ Endoscopy Lab
- □ ER
- □ Materials Management
- □ Nursing Stations (ICU, NSY, Med Surg)
- □ Operating Room
- □ Pharmacy
- □ Radiology Department
- □ Respiratory
- □ Sterile Supply
- □ Other: __________________________

**DHP Signature:** ____________________________ **Date:** ____________________________

**DHP Company/Vendor:** ____________________________

DHP Credentialing.parallonwms@parallon.com 1-800-737-8661 ext. 1440 1-866-361-2812 (secure e-fax)
1000 Sawgrass Corporate Parkway 6th Floor – Sunrise, Florida 33323 Attention: DHP Credentialing. Updated 8-15