Surgical Privileges Form: Vascular Surgery

Clinical Privileges Request

Applicant's Name: …… Scope of Practice: ……

License No. (If Any): …… Facility: ……

Date: …… Place of Work: ……

Privileges	Requested *(To be completed by the applicant)*	Recommended (For committee use)		Not Recommended (For committee use)
		Under Supervision	Independent	
CATEGORY I: Advanced Privileges				
1. Aneurysm repair, infrarenal aorta, suprarenal aorta, iliac, femoral, popliteal, emergent and elective.				
2. Angioplasty, femoral, iliac				
3. Aortoiliac bypass, aorto femoral bypass, axillo femoral bypass, brachiocephalic arterial bypass, femoral femoral bypass, visceral artery bypass, in situ saphenous vein bypass, carotid subclavian bypass				
4. Carotid endarterectomy – vertebral artery reconstruction				
5. Cervical, thoracic, or dorsal sympathectomy				
6. Intraoperative angioplasty, balloon dilatation				
7. Lumbar and cervical sympathectomy				
8. Thoracis arterial bypass procedures				
9. Other major peripheral vascular arterial and venous reconstructions				

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10. Percutaneous or operative insertion caval filter				
11. Percutaneous or open caval interruption				
12. Peritoneovenous shunts for chronic ascites				
13. Resection or repair of major vessels with anastomosis or replacement (excluding cardiopulmonary, intracranial)				
14. Thoracic outlet decompression procedures including rib resection				
15. Venous reconstruction				
16. Imaging:				
a. Intravascular ultrasonography				
b. Angioscopy				
17. Endovascular surgery				
a. Balloon angioplasty +/- stenting				
b. Endovascular grafting				
c. Vena cava filter placement				
d. Laparoscopy				
e. Endoscopic vascular surgery				
18. Endoscopic vascular surgery				
a. Thoracoscopy				
b. Laparoscopy				

CATEGORY II: Additional Privileges (not included above)

1.				
2.				
3.				
4.				

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5.				
6.				

Notes:

a) If additional privilege(s) are desired, please indicate this in the space provided above.
b) You must submit along with this application all necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.

By signing below, I acknowledge that I have read, understand, and agree to abide by QCHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

a) In exercising any clinical privileges granted, I am constrained by QCHP's policies and rules applicable generally and any applicable to the particular situation.
b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the recognized policies and rules.

…….. ……

Applicant's signature (Stamp if any) Date

…….. ……

1. Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signature Date

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For Committee use only

Evaluation Committee Chairman:

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and I have made the above-noted recommendation(s).

……. ……

Chairperson's Stamp & signature Date

Other Committee Members:

……. ……

1) Name Date

……. ……

2) Name Date

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