Surgical Privileges Form: "Cardiology"

Clinical Privileges Request

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

License No. (If Any): …….. Facility:……

Date: ……

CATEGORY I: Advanced Privileges

Privileges	Requested *(To be completed by the applicant)*	Recommended (For committee use)		Not Recommended (For committee use)
		Under Supervision	Independent	
1. Endotracheal Intubation				
2. Pharmacological Stress Testing				
3. Pericardiocentesis				
4. Invasive cardiology including the following:				
a. Complete heart catheterization with angiography				
b. Transvenous cardiac pacemaker placement – temporary				
c. Transvenous endomyocardial biopsy				
5. Interventional cardiology including the following:				
a. Percutaneous transluminal coronary angioplasty				
b. Primary Coronary Angioplasty				
c. Catheter extraction of Coronary thrombi				
d. Intra vascular Coronary Ultrasound				

e. Coronary Flow Reserve Measurements (FFR)				
f. Directional coronary atherectomy				
g. Coronary stent placement				
h. Excimer laser angioplasty				
i. Rotoblator atherectomy				
j. Transluminar extraction catheter (TEC)				
k. Peripheral vascular angiography/ angioplasty/interventional procedures				
l. Transseptal puncture				
m. Intra-Aortic Balloon Insertion				
n. Percutaneous balloon mitral valvuloplasty				
6.Electrophysiology including the following:				
a. Cardiac electrophysiology studies				
b. Transvenous cardiac pacemaker placement – permanent				
c. Insertion program and programming				
7. Echocardiology, including the following:				
a. Transesophageal echocardiography				
b.Transvenous endomyocardial biopsy				
8. Balloon valvuloplasty				
9. Intravascular ultrasound procedure				
10. Shunt – device closure				

CATEGORY II: Additional Privileges:

1.				
2.				
3.				
4.				
5.				

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Notes:

- If additional privilege(s) are desired, please indicate this in the space provided above.
- 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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