Surgical Privileges Form:
Vascular Surgery (Core Privileges)

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	
Core Privileges				
1. Amputations, lower extremity				
2. Brachial, femoral embolectomy or thrombectomy				
3. Central venous access catheters and ports				
4. Endarterectomy other than carotid				
5. Hemodialysis access procedures				
6. Intraoperative angiography				
7. Resection or repair of peripheral artery or vein with anastomosis or replacement				
8. Revascularization of amputated parts				
9. Sclerotherapy				
11. Vein ligation and stripping				
12. Imaging:				
a. Duplex ultrasonography				
b. Contrast angiography				

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13. Thrombolysis				
a. Percutaneous catheter thrombolysis				
b. Intraoperative thrombolysis				
14. Endoscopic vascular surgery				
a. Saphenous vein harvesting				
15. Skin grafting at the site of fasciotomy and amputation stump				

Note: 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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Name of Applicant: ----------

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

…….. ……

1) Name Date

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