Surgical Privileges Form: Neurosurgery

Clinical Privileges Request

(Advanced Privileges/for Specialty Only)

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

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

Date: ……..

Instructions

For applicant:

1. **Please note that you should sign next to each requested privilege.**
2. **Please use this sign (√) for the requested privilege.**
3. **Please leave any procedures you do not want to apply for blank and do not use (X) sign.**
4. **Please do not write additional privilege out of your scope of practice, as it will not be accepted.**
5. **Please do not write anything in the "for committee Use "section.**
6. **For additional privilege, do not choose the already granted privilege.**
7. **Please attach the previous approval of surgical privilege when you apply for additional privilege.**
8. **Please note that you can apply for Appeal within one month of the date of Issuance of the Privilege.**
9. **You can only apply Once for Appeal per a single Privilege Application.**

For committee:

1. **Please note that the final decision must be signed by minimum 2 committee members.**
2. **Please use this sign (√) for recommended and not-recommended privilege.**
3. **Please note that granting privileges under supervision is not permitted. Please do not write "under supervision" note next to any privilege.**
4. **Please specify the reasons for rejection (if applicable); for example (require experience, logbook is insufficient, need additional courses, etc.)**

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CATEGORY I: Advanced Privileges

A. Cranial Procedures

Privileges	*For applicant use*		*For committee use*		
	Request	***Signature***	***Recommended***	***Not Recommended***	***Reason for rejection (if any)***
1. Surgery for deep and complex skull base tumors					
2. Surgery for cerebral aneurysm or Arterio Venous Malformation and other vascular lesions					
3. Posterior fossa-microvascular decompression procedures					
4. Trans sphenoidal surgery for sellar / para /supra sellar lesions and Repair of Cerebro spinal fluid leak					
5. Robot assisted surgery for brain biopsy and resection					
6. Cranial endoscopic procedures including 3rd ventriculostomy and others					
7. Insertion of depth electrodes/subdural mats/electrodes for epilepsy					
8. Ablative surgery for epilepsy					
9. Steriotactic deep brain stumation					
10. Steriotactic radiosurgery					

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B. Spinal Procedures / Surgeries

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Endoscopic Minimally invasive Surgery					
2. Cordotomy, rhizotomy and spinal cord 5. stimulators for the relief of pain					
3. Selective blocks for pain medicine, stellate ganglion blocks					
4. Surgery on the sympathetic nervous system					
5. Percutaneous neucleoplasty for disc disease					

C. Surgery for Congenital Anomalies

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Surgery for craniosynostosis					

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D. Endovascular Procedures

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Transarterial and transvenous catheterization of the arteries and veins of the Central Nervous System, skull, face, neck, and spine.					
2. Embolization of arterial and venous vascular lesions of the central nervous system and the vessels supplying the structures of the Central Nervous System, skull, face, neck, and spine with embolic agents including but not limited to coils, glue, and particles.					
3. Intracranial arterial stent placement.					
4. Spinal angiography					
5. Intra-arterial and intra-venous injection of thrombolytic agents for clot lysis therapy in vessels supplying or draining the Central Nervous System or its related bony and soft tissue structures.					
6.Intra-arterial and intra-venous injection of non-thrombolytic agents for diagnostic testing and treatment of disease in vessels supplying or draining the CNS or its related bony and soft tissue structures.					

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CATEGORY II: Additional Privileges:

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*

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.
- Granting privileges under supervision is no longer permitted

By signing below, I acknowledge that I have read, understand, and agree to abide by DHP 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 DHP'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

…….. ……

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

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For Committee use only

Committee Decision:

Evaluation type:

By Interview	☐	virtual / personal
By documents only	☐	
Or both	☐	

Other comments:

……

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