ADVANCED SURGICAL PRIVILEGES FORM / CARDIOLOGY

Applicant's Name: .....

License No. (If Any): ..... Date: D D M M Y Y Y Y

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

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

Additional privilege (not included above)

Privileges	For applicant use		For committee use				
	Request	Signature	Recommended			Not Recommended	Reason for rejection (if any)
			Facility type				
			Hospital	Day care	Clinic under LA		

Note:
You must submit along with this application all necessary document(s) to support your request.

Applicant's signature ..... Date: D D M M Y Y Y Y

ADVANCED SURGICAL PRIVILEGES FORM / CARDIOLOGY

FOR COMMITTEE USE ONLY

Committee Decision:

Evaluation type:

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

Other comments:

.....

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

Clinical privileging committee members:

.....
Name, Signature & Stamp

Date: D D M M Y Y Y Y

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Name, Signature & Stamp

Date: D D M M Y Y Y Y

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Name, Signature & Stamp

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