ADVANCED SURGICAL PRIVILEGES FORM / VASCULAR SURGERY

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. 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 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	☐		☐	☐	
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	☐		☐	☐	

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Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
17. Endovascular surgery					
a. Balloon angioplasty +/- stenting	☐		☐	☐	
b. Endovascular grafting	☐		☐	☐	
c. Vena cava filter placement	☐		☐	☐	
18. Endoscopic vascular surgery					
a. Thoracoscopy	☐		☐	☐	
b. Laparoscopy	☐		☐	☐	

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

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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:

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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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