CORE 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. In-house consultation	☐		☐	☐	
2. Interpretation and reporting of EKG/Holter to include rhythm disorders	☐		☐	☐	
3. Interpretation of X-rays	☐		☐	☐	
4. Emergency needle Tracheostomy	☐		☐	☐	
5. Treadmill Exercise stress testing	☐		☐	☐	
6. Perform/Interpret transthoracic echocardiogram with doppler	☐		☐	☐	
7. Elective cardioversion	☐		☐	☐	
8. Exercise stress echocardiography	☐		☐	☐	

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:

.....
Name, Signature & Stamp

Date: D D M M Y Y Y Y

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Name, Signature & Stamp

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