CORE SURGICAL PRIVILEGES FORM / PULMONOLOGY

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. Diagnostic thoracentesis (diagnostic pleural tapping)	☐		☐	☐	
2. Pleural catheter insertion	☐		☐	☐	
3. Application and management of non-invasive ventilation (e.g., CPAP and Bi-PAP)	☐		☐	☐	

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

CORE SURGICAL PRIVILEGES FORM / PULMONOLOGY

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

.....
Name, Signature & Stamp

Date: D D M M Y Y Y Y

.....
Name, Signature & Stamp

Date: D D M M Y Y Y Y

.....
Name, Signature & Stamp

Date: D D M M Y Y Y Y

.....
Name, Signature & Stamp

Date: D D M M Y Y Y Y

.....
Name, Signature & Stamp

Date: D D M M Y Y Y Y

.....
Name, Signature & Stamp

Date: D D M M Y Y Y Y

.....
Name, Signature & Stamp

Date: D D M M Y Y Y Y