CORE 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. Amputations, upper extremity	☐		☐	☐	
2. Amputations, lower extremity	☐		☐	☐	
3. Brachial, femoral embolectomy or thrombectomy	☐		☐	☐	
4. Central venous access catheters and ports	☐		☐	☐	
5. Endarterectomy other than carotid	☐		☐	☐	
6. Hemodialysis access procedures	☐		☐	☐	
7. Intraoperative angiography	☐		☐	☐	
8. Resection or repair of peripheral artery or vein with anastomosis or replacement	☐		☐	☐	
9. Revascularization of amputated parts	☐		☐	☐	
10. Sclerotherapy	☐		☐	☐	
11. Vein ligation and stripping	☐		☐	☐	
12. Imaging					
a. Duplex ultrasonography	☐		☐	☐	
b. Contrast angiography	☐		☐	☐	
13. Thrombolysis					
a. Percutaneous catheter thrombolysis	☐		☐	☐	
b. Intraoperative thrombolysis	☐		☐	☐	
14. Endoscopic vascular surgery					
a. Saphenous vein harvesting	☐		☐	☐	
15. Skin grafting at the site of fasciotomy and amputation stump	☐		☐	☐	

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: DD MM YYYY

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Name, Signature & Stamp

Date: DD MM YYYY

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