Surgical Privileges Form: Vascular Surgery

(Advanced Privileges/for Specialist Only)

Clinical Privileges Request

Applicant's Name: ………………………………………… Scope of Practice: ……………………….

License No. (If Any): ………………………………………….. Facility: ……………………………………..

Date: ………………………………………………………………………..

Instructions

For applicant:

1. **Please note that you should sign next to each requested privilege.**
2. **Please use this sign (√) for the requested privilege.**
3. **Please leave any procedures you do not want to apply for blank and do not use (X) sign.**
4. **Please do not write additional privilege out of your scope of practice, as it will not be accepted.**
5. **Please do not write anything in the "for committee Use "section.**
6. **For additional privilege, do not choose the already granted privilege.**
7. **Please attach the previous approval of surgical privilege when you apply for additional privilege.**
8. **Please note that you can apply for Appeal within one month of the date of Issuance of the Privilege.**
9. **You can only apply Once for Appeal per a single Privilege Application.**

For committee:

1. **Please note that the final decision must be signed by minimum 2 committee members.**
2. **Please use this sign (√) for recommended and not-recommended privilege.**
3. **Please note that granting privileges under supervision is not permitted. Please do not write "under supervision" note next to any privilege.**
4. **Please specify the reasons for rejection (if applicable); for example (require experience, logbook is insufficient, need additional courses, etc.)**

This information has been labeled as Public information

Surgical Privileges Form: Vascular Surgery

(Advanced Privileges/for Specialist Only)

CATEGORY I: Advanced Privileges

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					

This information has been labeled as Public information

(Advanced Privileges/for Specialist Only)

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

This information has been labeled as Public information

(Advanced Privileges/for Specialist Only)

Privileges	*For applicant use*		*For committee use*		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
d. Laparoscopy					
e. Endoscopic vascular surgery					
18. Endoscopic vascular surgery					
a. Thoracoscopy					
b. Laparoscopy					

CATEGORY II: Additional Privileges (not included above)

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

This information has been labeled as Public information

Surgical Privileges Form: Vascular Surgery **Clinical Privileges Request**

(Advanced Privileges/for Specialist Only)

Note:

- If additional privilege(s) are desired, please indicate this in the space provided above. You must submit along with this application a necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.
- Granting privileges under supervision is no longer permitted

By signing below, I acknowledge that I have read, understand, and agree to abide by DHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

1. In exercising any clinical privileges granted, I am constrained by DHP's policies and rules applicable generally and any applicable to the particular situation.
2. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the recognized policies and rules.

………………………………………………. ……………………….

Applicant’s signature (Stamp if any) Date

………………………………………………. ……………………….

Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signature Date

This information has been labeled as Public information

(Advanced Privileges/for Specialist Only)

For Committee use only

Committee Decision:

Evaluation type:

By Interview ☐ virtual / personal

By documents only ☐

Or both ☐

Other comments:

……

Evaluation Committee Chairman:

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

………………………………………………….. ………………………….
Chairperson's Stamp & signature Date

Other Committee Members:

………………………………………………….. ………………………….

1) Name Date
………………………………………………….. ………………………….
2) Name Date

This information has been labeled as Public information