ADVANCED SURGICAL PRIVILEGES FORM / CARDIAC SURGERY

Applicant's Name: ....

License No. (If Any): .... Date: DD MM YYYY

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Coronary Artery Bypass Grafting (CABG)					
a. Endoscopic vein harvesting	☐		☐	☐	
b. Endoscopic radial artery harvesting	☐		☐	☐	
c. Off pump coronary artery bypass graft surgery (OPCAB)	☐		☐	☐	
d. Minimally invasive CABG					
• Robotic assisted coronary revascularization	☐		☐	☐	
• Endoscopy assisted coronary revascularization	☐		☐	☐	
2. Aortic valve					
a. Aortic valve replacement by homograft	☐		☐	☐	
b. Aortic valve replacement by sutureless valve	☐		☐	☐	
c. Aortic valve repair	☐		☐	☐	
d. Aortic root replacement (Bentall operation)	☐		☐	☐	
e. Aortic valve replacement by pulmonary autograft (Ross operation)	☐		☐	☐	
f. Aortic valve sparing-root replacement operation	☐		☐	☐	
g. Minimally invasive aortic valve surgery					
• Endoscopy-assisted aortic valve surgery	☐		☐	☐	
• Robot-assisted aortic valve surgery	☐		☐	☐	
h. Aortic valve replacement by sutureless valve (TAVR)	☐		☐	☐	
3. Aorta					
a. Repair of aortic dissection	☐		☐	☐	
b. Repair of aortic arch aneurysm	☐		☐	☐	

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c. Repair of descending aortic aneurysm	☐		☐	☐	
d. Repair of aortic coarctation	☐		☐	☐	
e. Repair of traumatic aortic injury	☐		☐	☐	
4. Mitral Valve					
a. Mitral valve repair	☐		☐	☐	
b. Minimally invasive mitral valve surgery					
• Endoscopy assisted mitral valve	☐		☐	☐	
• Robot assisted mitral valve surgery	☐		☐	☐	
c. Trans-catheter mitral valve procedure	☐		☐	☐	
5. Tricuspid valve					
a. Transcatheter tricuspid valve procedure	☐		☐	☐	
6. Pulmonary valve					
a. Transcatheter pulmonary valve procedure	☐		☐	☐	
7. Ventricles					
a. Myectomy for hypertrophic cardiomyopathy	☐		☐	☐	
b. Left ventricular aneurysm repair	☐		☐	☐	
c. Repair of ischemic ventricular septal rupture	☐		☐	☐	
d. Repair of ischemic ventricular free wall rupture	☐		☐	☐	
8. Cardiac lesions (other than myxomas)	☐		☐	☐	
9. Arrhythmia surgery: surgical ablation for atrial fibrillation	☐		☐	☐	
10. Pericardiectomy	☐		☐	☐	
11. Pulmonary thromboembolism					
a. Pulmonary thromboembolectomy	☐		☐	☐	
b. Pulmonary endarterectomy	☐		☐	☐	

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Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
12. Mechanical circulatory support					
a. Temporary mechanical circulatory support					
• Extracorporeal membrane oxygenation (ECMO)	☐		☐	☐	
• Temporary ventricular assist devices	☐		☐	☐	
b. Durable ventricular assist devices (LVAD, RVAD, and BIVAD)	☐		☐	☐	
13. Heart transplant	☐		☐	☐	
14. Adult congenital					
a. Repair of primary atrial septal defect	☐		☐	☐	
b. Repair of ventricular septal defect	☐		☐	☐	
c. Repair of subaortic membrane	☐		☐	☐	
d. Repair of anomalous origin of coronary arteries	☐		☐	☐	

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: DD MM YYYY

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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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