CORE SURGICAL PRIVILEGES FORM / CARDIAC 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. General					
a. Sternotomy	☐		☐	☐	
b. Re-exploration for postoperative bleeding	☐		☐	☐	
c. Sternotomy wound revision and debridement	☐		☐	☐	
d. Reopening and closure of surgical wounds outside the operating theatre	☐		☐	☐	
e. Pleural drainage (thoracostomy tube or thoracocentesis)	☐		☐	☐	
f. Surgical pericardial drainage	☐		☐	☐	
g. Insertion of intra-aortic balloon pump (IABP)	☐		☐	☐	
h. Epicardial lead placement	☐		☐	☐	
2. Coronary Artery Bypass Graft Surgery (CABG)					
a. Harvesting venous grafts	☐		☐	☐	
b. Harvesting internal mammary grafts	☐		☐	☐	
3. Aortic valve replacement (mechanical or tissue valves)	☐		☐	☐	
4. Mitral valve replacement (mechanical or tissue valve)	☐		☐	☐	
5. Tricuspid valve repair and replacement	☐		☐	☐	
6. Pulmonary valve repair and replacement	☐		☐	☐	
7. Repair of ascending aortic aneurysm	☐		☐	☐	
8. Repair of atrial septal defect (secundum ASD)	☐		☐	☐	
9. Excision of cardiac masses (myxoma and thrombus)	☐		☐	☐	
10. Traumatic cardiac injury	☐		☐	☐	

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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