Surgical Privileges Form: Neurosurgery Clinical Privileges Request

(Core Privileges / For Associate only)

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**
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.)**

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Clinical Privileges Request

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CATEGORY I: Cranial Procedures

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Surgery for cranial trauma					
2. Surgery for convexity/superficial brain tumors					
3. Surgery for posterior fossa brain tumors					
4. Steriotactic guided surgery for brain lesions including biopsy and micro craniotomy					

CATEGORY II: Spinal Procedures / Surgeries

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Epidural steroid injections for pain					
2. Insertion of subarachnoid or epidural catheter with reservoir or pump for drug infusion					
3. Lumbar subarachnoid-peritoneal shunt					
4. Radiofrequency ablation					

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Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
5. Spinal cord surgery for decompression of spinal cord or spinal canal, for intramedullary lesion, intradural extramedullary lesion, rhizotomy, cordotomy, dorsal root entry zone lesion, tethered spinal cord or other congenital anomalies (diastematomyelia)					
6. Laminectomies, laminotomies and fixation and reconstructive procedures of spine and its contents including instrumentation					
7. Surgery for intervertebral disc disease					
8. Percutaneous vertebroplasty Balloon kyphoplasty					

CATEGORY III: Peripheral Nerve Procedures

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Peripheral nerve procedures, including decompressive procedures and reconstructive procedures on the peripheral nerves					
2. Nerve blocks					
3. Nerve biopsy					
4. Muscle biopsy					

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CATEGORY IV: Other Procedures

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Intra Cranial Pressure insertion					
2. Lumbar Drain					
3. External Ventricular Drain					
4. Lumbar puncture, cisternal puncture, ventricular tap, subdural tap					
5. Shunts: ventriculoperitoneal, ventriculoatrial, ventriculopleural, subdural peritoneal, lumbar subarachnoid/peritoneal (or other cavity)					

CATEGORY V: Surgery for Congenital Anomalies

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Surgery for Chairi malformation					
2. Management of congenital anomalies, such as encephalocele, meningocele, myelomeningocele					

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CATEGORY VI: Endovascular Procedures

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Performing and interpreting diagnostic imaging studies related to the vasculature of the Central Nervous System, head, neck, and spine.					
2. Participating in short-term and long-term post procedure follow-up care, including neurointensive care					

CATEGORY **VII**: Additional Privileges:

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Craniostomy for chronic subdural hematoma					
2. Craniotomy for spontaneous intracranial hemorrhage					
3. Wound debridement, surgical treatment of post rupture CSF leak (pseudo meningocele)					
4. Surgery for skull lesions (dermoid, osteoma, eosinophilic, granuloma)					
5. Trans-sphenoidal surgery for pituitary adenoma					
6. Injection for Carpal Tunnel Syndrome					
7. All types of pain management by injection (cervical, dorsal, lumbar)					

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Note:

- You must submit along with this application all 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:

a) In exercising any clinical privileges granted, I am constrained by DHP's policies and rules applicable generally and any applicable to the particular situation.
b) Any restriction on the clinical privileges granted to me is waived in an emergency 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 Date

will perform surgeries in) Stamp & Signature

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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

…….. ……

1) Name Date