

REQUEST FOR ANESTHESIA PRIVILEGES

Include this request with your application for staff membership

Applicant Name: _____

Date Requesting Privileges: _____

By submitting this request for privileges, I am attesting to the fact that I personally have the professional training and experience to perform the procedures I am outlining here in my request. I understand that I may not request a procedure in which I have not been professionally trained to perform either in residency, fellowship, or by proctoring process. My procedures are validated by my past acute care experience or by my prior surgery center experience whereby I had the same procedures of which I have volume of past cases to provide for validation.

PRIVILEGES REQUESTED, CLICK THE BOX OF THOSE PROCEDURES YOU WISH TO PERFORM	GOVERNING BODY HAS MET AND DETERMINED WHETHER TO GIVE YOU PERMISSION OR NOT TO PERFORM THESE PROCEDURES YOU'VE REQUESTED.		SPECIAL COMMENTS
General Anesthesia:			
<input type="checkbox"/> Pediatric	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YOU CHOOSE PEDIATRIC, THEN YOU MUST ALSO CHECK PALS ON PAGE 2
<input type="checkbox"/> Adult	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Local stand-by	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Intravenous regional block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Regional Anesthesia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Lumbar epidural block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Axillary block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Caudal block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Interscalene block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Blocks of nerves of upper and lower extremities	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Stellate ganglion block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Epidural Block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Spinal Block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Bier Block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Axillary nerve block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Trigger Point block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Occipital nerve block	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> BCLS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> ACLS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ACLS IS REQUIRED OF ALL MD(S) AND CRNA(S)
<input type="checkbox"/> IV Sedation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Monitored Anesthesia Care (MAC)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> IntraDiscal ElectroThermal Therapy (IDET)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

<input type="checkbox"/> Radiography Use of Modality & interpretation of images (therapeutic and diagnostic)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Ultrasound Use of Modality & interpretation of images (therapeutic and diagnostic)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Fluoroscopy Use of Modality with State License & interpretation of images (therapeutic & diagnostic)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Local anesthesia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Conscious Sedation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> Supervision of Conscious Sedation Trained Registered Nurse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> History & Physical	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
OTHERS NOT LISTED			
<input type="checkbox"/>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> PALS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

The Governing Body will meet to review your file only after all processes have been completed by the credentials verification staff. If you failed to provide any documents (i.e. license, malpractice, acls, etc.) that have been requested of you, this will only delay your approval date.

Applicant Print Name

Signature of Applicant

Date

Signature of Governing Body Chairperson

Date