Applicant's Name

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PAIN MANAGEMENT

I hereby request privileges in the specialty of Anesthesia as shown on this form. I understand that privileges granted are subject to a bi-annual review coinciding with reapplication for medical staff membership. I also understand that application for additional or new procedures can be made at any time with proper documentation.
Documentation of training and experience is attached for those procedures marked by an asterisk (*). The following privileges are requested and are consistent with my abilities, training and experience.

Applied for	Approved	Denied
General Anesthesia for		
❑ Pediatric	❑ YES	❑ NO
❑ Adult	❑ YES	❑ NO
❑ Local stand-by	❑ YES	❑ NO
❑ Intravenous regional block	❑ YES	❑ NO
❑ Regional Anesthesia	❑ YES	❑ NO
❑ Lumbar epidural block	❑ YES	❑ NO
❑ Axillary block	❑ YES	❑ NO
❑ Caudal block	❑ YES	❑ NO
❑ Interscalene block	❑ YES	❑ NO
❑ Blocks of nerves of upper and lower extremities	❑ YES	❑ NO
❑ Stellate ganglion block	❑ YES	❑ NO
❑ Epidural Block	❑ YES	❑ NO
❑ Spinal Block	❑ YES	❑ NO
❑ Bier Block	❑ YES	❑ NO
❑ Axillary nerve block	❑ YES	❑ NO
❑ Trigger Point block	❑ YES	❑ NO
❑ Occipital nerve block	❑ YES	❑ NO
❑ BCLS	❑ YES	❑ NO
❑ ACLS	❑ YES	❑ NO
❑ IV Sedation	❑ YES	❑ NO
❑ Monitored Anesthesia Care	❑ YES	❑ NO
❑ IntraDiscal ElectroThermal Therapy (IDET)	❑ YES	❑ NO
❑ Radiography Use of Modality & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO

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❑ Ultrasound Use of Modality & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Fluoroscopy Use of Modality with State License & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Local anesthesia	❑ YES	❑ NO
❑ Conscious Sedation	❑ YES	❑ NO
❑ Supervision of Conscious Sedation Trained Registered Nurse	❑ YES	❑ NO
❑ OTHERS NOT LISTED	❑	❑
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

_____ _____

Signature of Applicant Date

_____ _____

Signature of Medical Director Date recommended

_____ _____

Signature of Managing Member Date recommended