Applicant's Name

_____

CARDIOLOGY

I hereby request surgical privileges in the specialty of Cardiology Surgery as shown in 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 (*) and those procedures that are outside of your original specialty training.

Please indicate with an "X" in the appropriate box and by signature at the end of this document the procedures you are requesting privileges for.

Applied for	**Approved**	
CATEGORY I: Core Privileges of AMBULATORY SURGERY ❑ CARDIOLOGY: Work-up , evaluation, diagnosis, consultation, and/or provision of treatment to patients presenting with cardiovascular disease or disorders and related internal medicine disorders.	❑ YES	❑ NO
CATEGORY II: SPECIAL CARDIOLOGY PROCEDURES Special Privileges which may require additional training/experience:		
NON-INVASIVE TESTING:		
❑ EKG INTERPRETATION	❑ YES	❑ NO
❑ Echocardiography Interpretation	❑ YES	❑ NO
❑ Nuclear Cardiac Testing	❑ YES	❑ NO
❑ Graded exercise stress testing	❑ YES	❑ NO
BASIC CARDIAC INTERVENTIONAL TESTING AND TREATMENT:	❑ YES	❑ NO
❑ Swan Ganz Catheterization	❑ YES	❑ NO
❑ Transesophageal echocardiography	❑ YES	❑ NO
❑ Endomyocardial biopsy	❑ YES	❑ NO
❑ Pericardiocentesis	❑ YES	❑ NO
❑ Percutaneous pericaridiotomy	❑ YES	❑ NO
❑ Cardiac Catheterization	❑ YES	❑ NO
❑ Coronary angiography	❑	❑
❑ Thrombolytic therapy	❑ YES	❑ NO
❑ Non-selective aortic, iliac and renal flushes associated with cardiac catheterization	❑ YES	❑ NO
BASIC CARDIO-ELECTROPHYSIOLOGY TESTING/TREATMENT:		

❑ Cardioversion- medical and electrical	❑	❑
❑ Temporary pacer	❑ YES	❑ NO
❑ Permanent pacer	❑ YES	❑ NO
CATEGORY III: ADVANCED CARDIOLOGY PROCEDURES Advanced Privileges which require additional documentation of training/proficiency	❑ YES	❑ NO
ADVANCED CARDIAC INTERVENTIONAL PROCEDURES:	❑ YES	❑ NO
❑ Intra-aortic balloon pump placement	❑ YES	❑ NO
❑ Balloon valvuloplasty	❑ YES	❑ NO
❑ Percutaneous Transcoronary angioplasty	❑ YES	❑ NO
❑ Coronary stent placement	❑ YES	❑ NO
❑ Coronary atherectomy	❑ YES	❑ NO
STENTING	❑	❑
❑ ARTERIAL	❑ YES	❑ NO
❑ CORONARY	❑ YES	❑ NO
❑ CAROTID	❑ YES	❑ NO
❑ FEMORAL	❑	❑
❑ ILIAC	❑ YES	❑ NO
ADVANCED CARDIO-ELECTROPHYSIOLOGY TESTING/TREATMENT:	❑ YES	❑ NO
❑ Electrophysiology studies	❑ YES	❑ NO
❑ Radiofrequency ablation	❑ YES	❑ NO
❑ Lead extraction	❑ YES	❑ NO
❑ ICD placement	❑ YES	❑ NO
CATEGORY IV: CRITICAL CARE PRIVILEGES Special advanced critical care procedures which will require additional documentation of training/recency of experience (NOTE IF REQUESTING FOR EMERGENCY ONLY):		
❑ Patient Management in the PACU while awaiting Acute Transport to higher level of care	❑ YES	❑ NO
❑ Arterial cannula placement	❑ YES	❑ NO
❑ Endotracheal Intubation	❑ YES	❑ NO
❑ CVP line placement	❑ YES	❑ NO
❑ Ventilatory support management	❑ YES	❑ NO
❑ Chest tube insertion	❑ YES	❑ NO
❑ Cut down	❑ YES	❑ NO
❑ Pacemaker Insertion	❑ YES	❑ NO
❑ Generator Change	❑ YES	❑ NO
❑ Lead Change	❑ YES	❑ NO
❑ Loop Recorder	❑ YES	❑ NO

APPLIED FOR	APPROVAL	
The applicant must check the boxes to the left, the right side boxes are used for formal approvals of the governing body.	❑ YES	❑ NO
❑ IVUS	❑ YES	❑ NO
❑ Visceral Arteries Angiogram PTA and Stent	❑ YES	❑ NO
❑ Renal Artery Angiogram PTA and Stent	❑ YES	❑ NO
❑ Carotid Angiogram	❑ YES	❑ NO
❑ Venous Ablation	❑ YES	❑ NO
❑ Angioplasty and Stent	❑ YES	❑ NO
❑ Insertion and removal of dialysis catheter	❑ YES	❑ NO
❑ Fistulogram, angioplasty and stent	❑ YES	❑ NO
❑ Coiling	❑ YES	❑ NO
❑ Venogram, angioplasty and stent	❑ YES	❑ NO
❑ Thrombectomy	❑ YES	❑ NO
❑ Creation of percutaneous fistula	❑ YES	❑ NO
❑ Embolization	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑ Right Heart Cath	❑ YES	❑ NO
❑ Peripheral Angioplasty and Stent	❑ YES	❑ NO
❑ Atherectomy	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑ History and Physical	❑ YES	❑ NO
❑ Conscious Sedation	❑ YES	❑ NO
❑ Supervision of Conscious Sedation RN or other Advanced Allied Professional	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

Applicant Print Name

Signature of Applicant

Date

Signature of QI Committee Chairperson

Date

Signature of Governing Body Chairperson

Date