REQUEST FOR SURGICAL PRIVILEGES

I hereby request privileges in the specialty of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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.

The following privileges are requested and are consistent with my abilities, training, and experience.

Documentation of training and experience is attached for all procedures requested as in the form of approved delineated privileges approved by either the acute care hospital or the outpatient ambulatory surgery center setting. Having the experience from one of these institutions can be used as the proof of my experience coupled by college, residency, and fellowships herein.

| **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 |
|  | * YES | * NO |
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|  | * YES | * NO |
| * Local anesthesia | * YES | * NO |
| * Conscious Sedation | * YES | * NO |
| * Supervision of Conscious Sedation Trained Registered Nurse | * YES | * NO |
| * History & Physical | * YES | * NO |
| **OTHER PROCEDURES** | | |
|  | * YES | * NO |
|  | * YES | * NO |
|  | * 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