



**Surgical Privileges Form:
Vascular Surgery**

Clinical Privileges Request

Applicant's Name:

Scope of Practice:

License No. (If Any):

Facility:

Date:

Place of Work:

Privileges	For applicant use		For committee use		
	Request	Signature	Recommen- -ded	Not Recommended	Signature

CATEGORY I: Advanced Privileges

1. Aneurysm repair, infrarenal aorta, suprarenal aorta, iliac, femoral, popliteal, emergent and elective.					
2. Angioplasty, femoral, iliac					
3. Aortoiliac bypass, aorto femoral bypass, axillo femoral bypass, brachiocephalic arterial bypass, femoral femoral bypass, visceral artery bypass, in situ saphenous vein bypass, carotid subclavian bypass					
4. Carotid endarterectomy – vertebral artery reconstruction					
5. Cervical, thoracic, or dorsal sympathectomy					
6. Intraoperative angioplasty, balloon dilatation					
7. Lumbar and cervical sympathectomy					
8. Thoracic arterial bypass procedures					
9. Other major peripheral vascular arterial and venous reconstructions					
10. Percutaneous or operative insertion caval filter					



11. Percutaneous or open caval interruption					
12. Peritoneovenous shunts for chronic ascites					
13. Resection or repair of major vessels with anastomosis or replacement (excluding cardiopulmonary, intracranial)					
14. Thoracic outlet decompression procedures including rib resection					
15. Venous reconstruction					
16. Imaging:					
a. Intravascular ultrasonography					
b. Angioscopy					
17. Endovascular surgery					
a. Balloon angioplasty +/- stenting					
b. Endovascular grafting					
c. Vena cava filter placement					
d. Laparoscopy					
e. Endoscopic vascular surgery					
18. Endoscopic vascular surgery					
a. Thoracoscopy					
b. Laparoscopy					

CATEGORY II: Additional Privileges (not included above)

1.					
2.					
3.					
4.					



Notes:

- a) If additional privilege(s) are desired, please indicate this in the space provided above.
- b) 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.
- c) Granting privileges under supervision is no longer permitted

By signing below, I acknowledge that I have read, understand, and agree to abide by QCHP 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 QCHP'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 situation and in such situation my actions are governed by the recognized policies and rules.

.....
Applicant's signature (Stamp if any)

.....
Date

.....
1. Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signature

.....
Date



For Committee use only

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

.....
2) Name

.....
Date