



**Surgical Privileges Form:
Cardiology (Core Privileges)**

Clinical Privileges Request

Applicant's Name:

Scope of Practice:

License No. (If Any):

Facility:

Date:

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

Core Privileges

1. In-house consultation					
2. Interpretation and reporting of EKG/Holter to include rhythm disorders					
3. Interpretation of X-rays					
4. Emergency needle Tracheostomy					
5. Treadmill Exercise stress testing					
6. Perform/Interpret transthoracic echocardiogram with Doppler					
7. Elective cardioversion					
8. Exercise stress echocardiography					

Note:

- 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.
- 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.

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Applicant's signature (Stamp if any)

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Date

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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).

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Chairperson's Stamp & signature

.....
Date

Other Committee Members:

.....
1) Name

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Date

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1) Name

.....
Date