



CORE PRIVILEGES
Cardiology Services

Qualifications: MD or DO with successful completion of an accredited ACGME/AOA residency training program of at least three years in Internal medicine, board certification by the ABMS or AOA in Internal Medicine, and successful completion of an approved three (3) year accredited program in Cardiology. Board certification by the ABMS or AOA in Cardiology is required within three (3) years of completion of the training program.

Special Procedures: Applicants seeking (or renewing) special privileges outside of the core must demonstrate to the Credential/MEC/Board that they are competent to perform the privilege(s) requested by any of the three methods: 1) have performed the procedure(s) in high enough volume within the past 2-years that any quality trends might be detectable; 2) have references attesting to current competency; or 3) have a proctor attest to clinical competency after evaluation of observed performance.

(R)= Recommended as Requested (A)=Approved as Requested (C)=Recommended with Condition(s) (N)=Not Recommended

Requested						
Yes	No		(R)	(A)	(N)	(C) Condition/Reason(s)
		CORE PRIVILEGES:				
		Comprehensive consultation, evaluation, diagnosis, and treatment of patients of all ages with cardiovascular disease, to included but not limited to <ul style="list-style-type: none"> ▪ Interpret ECGs, holter monitors, and exercise tests ▪ Perform and supervise pharmacologic and nuclear stress testing ▪ Perform and interpret Transthoracic and Transesophageal echos (M Mode, 2 D and Doppler) ▪ Thermal dilutional catheter insertion (Swan ganz catheterization) ▪ Direct current cardioversion (DCC) ▪ Cardioversion using IV sedation ▪ IV thrombolytic therapy for acute coronary artery disease ▪ Pericardiocentesis, ▪ Insertion and management of central venous and pulmonary artery catheters, temporary pacemakers, and arterial lines. 				
		Critical Care and Ventilator Management of patients admitted to the ICU with medical conditions including but not limited to unstable coronary artery disease, myocardial infarctions, severe congestive heart failure, valvular heart disease, and complex cardiac arrhythmias.				<i>Current certification in ACLS required</i>
		EKG Interpretation (i.e., official interpretation, pool reading – Official EKG readings are performed by qualified cardiologists having a contract with TRMC.				
		SPECIAL PROCEDURES:				
		Peripheral thrombolysis				
		Computed Tomography Angiogram				<i>satisfy ACCF/AHA requirements for training in cardiac CT</i>
		Administration of Moderate Sedation				<i>current ACLS certification and passage of proficiency exam for the selected anesthetic drug(s) of choice.</i>

		CARDIAC CATHETERIZATION AND ANGIOGRAPHY <i>(documentation of training required with verification of performance of at least 150 elective percutaneous coronary interventional procedures(PCI) within the past 24 months)</i>				
Requested						
Yes	No		(R)	(A)	(N)	(C) Condition/Reason(s)
		Right and left heart catheterization				
		Percutaneous Coronary Intervention: <ul style="list-style-type: none"> <input type="checkbox"/> Coronary Angioplasty <input type="checkbox"/> Coronary Stent Placement <input type="checkbox"/> Coronary Atherectomy (directional and/or rotational) <input type="checkbox"/> Coronary FFR (fractional flow reserve) measurements 				
		Invasive Angiography: <ul style="list-style-type: none"> <input type="checkbox"/> Coronary Angiogram <input type="checkbox"/> Carotid Angiogram <input type="checkbox"/> Renal Angiogram <input type="checkbox"/> Aortogram <input type="checkbox"/> Upper & lower extremities Angiography <input type="checkbox"/> AV Fistulogram <input type="checkbox"/> Venogram <input type="checkbox"/> Pulmonary Angiogram 				
		Percutaneous Peripheral Intervention: <ul style="list-style-type: none"> <input type="checkbox"/> Angioplasty <input type="checkbox"/> Inferior Vena Cava (IVC) filter placement <input type="checkbox"/> Stent Placement <input type="checkbox"/> Atherectomy (directional and/or rotational) 				
		Cardiac-assist procedures: <ul style="list-style-type: none"> <input type="checkbox"/> Intra-aortic Balloon Placement and Pump Therapy 				
		Cardiac Rhythm Management Device Implantation: <ul style="list-style-type: none"> <input type="checkbox"/> Transvenous Temporary Pacing Catheter Placement <input type="checkbox"/> Permanent Pacemaker Implantation (single and/or dual chamber) <input type="checkbox"/> Bi-Ventricular Pacemaker Implantation <input type="checkbox"/> Cardioverter-Defibrillator Implantation <input type="checkbox"/> Loop Recorder Implantation 				

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Teche Regional Medical Center.

Signature of Applicant

Date

Printed Name

Requested privileges reviewed and recommended as indicated above.

Signature of Service or Department Chair

Date

Board of Trustees' Decision

Teche Regional Medical Center's Board of Trustees

Does

Does not grant clinical privileges as requested

(if "does not" grant, give reasons in letter to the applicant with a copy of privilege list)

Secretary, Board of Trustees

Date



HEALTH STATEMENT

TO CHIEF OF SERVICE / CHIEF OF STAFF

1. I HEREBY CERTIFY THAT I POSSESS THE NECESSARY COGNITIVE AND MOTOR SKILLS TO SAFELY PERFORM ALL PRIVILEGES REQUESTED AND DECLARE MYSELF TO BE FREE FROM ANY CONDITION, ILLNESS, OR INFECTIOUS DISEASE THAT COULD COMPROMISE PATIENT CARE OR MY ABILITY TO PERFORM THE PRIVILEGES REQUESTED.

YES NO

2. IF NO, DO YOU HAVE A PHYSICAL OR MENTAL CONDITION OR ILLNESS (INCLUDING ANY CHEMICAL OR ALCOHOL DEPENDENCY) WHICH COULD AFFECT YOUR ABILITY TO EXERCISE THE CLINICAL PRIVILEGES REQUESTED WITHOUT SPECIAL ACCOMMODATIONS IN ORDER FOR YOU TO EXERCISE THE PRIVILEGES REQUESTED SAFELY AND COMPETENTLY? TO ANSWER THIS QUESTION APPROPRIATELY, PLEASE REPORT ANY CONDITION WHICH IS, OR MAY BE INFECTIOUS, COULD AFFECT MOTOR SKILLS, COGNITIVE ABILITY OR JUDGMENT, OR COULD POTENTIALLY ADVERSELY AFFECT YOUR ABILITY TO CARE FOR PATIENTS OR TO INTERACT APPROPRIATELY WITH OTHER CAREGIVERS.

YES NO

If yes, please explain:

3. HAVE YOU TESTED POSITIVE FOR THE TUBERCULIN SKIN TEST? YES NO
If yes, please give date of positive skin test. _____
If no, when was your last PPD test? _____

REGARDLESS OF HOW THIS QUESTION IS ANSWERED, THE APPLICATION WILL BE PROCESSED IN THE USUAL AND CUSTOMARY MANNER. IF YOU HAVE ANSWERED THIS QUESTION AFFIRMATIVELY AND ARE FOUND TO BE PROFESSIONALLY QUALIFIED FOR MEDICAL STAFF APPOINTMENT AND CLINICALLY COMPETENT TO PERFORM THE CLINICAL PRIVILEGES REQUESTED, YOU WILL BE GIVEN AN OPPORTUNITY TO MEET WITH THE EXECUTIVE COMMITTEE TO DETERMINE WHAT ACCOMMODATIONS, IF ANY, ARE NECESSARY TO ALLOW YOU TO PRACTICE SAFELY.

SIGNATURE OF APPLICANT

DATE

CHIEF OF SERVICE

DATE