



CORE PRIVILEGES

GENERAL VASCULAR SURGERY

QUALIFICATIONS:

- Completion of 12-month fellowship or similar training in peripheral vascular surgery
- Current certification by the American Board of Surgery and board certified or eligible for board certification in vascular surgery by the VSB-ABS
- Documentation or attestation of the performance of at least 50 vascular surgical cases during the past two (2) years. **Reappointments: please be prepared to provide a list of cases performed at facilities other than Teche Regional Medical Center if requested.**

(R)= Requested (A)=Recommended as Requested (C)=Recommended with Conditions (N)=Not Recommended

(R)	[You may mark through any privilege you will not be doing at this facility and do not wish to request]	(A)	(C)	(N)	Condition/Reason(s)
	CORE PRIVILEGES:				
	Comprehensive consultation, differential diagnosis and treatment planning of conditions including:				
	<u>Arterial Disease</u> (excluding coronary arteries, ascending aorta, aortic arch, descending thoracic aorta, pulmonary arteries, and intracranial arteries) <ul style="list-style-type: none"> ▪ Diagnosis and medical therapy of aneurismal, obstructive, traumatic, neoplastic, and infectious arterial diseases ▪ Interpretation of vascular ultrasound studies, extremity plethysmography studies, segmental arterial pressure studies, transcutaneous oxygen studies ▪ Intraoperative arteriography ▪ Angioscopy ▪ Catheter or open embolectomy/thrombectomy ▪ Endarterectomy ▪ Resection with or without graft replacement ▪ Arterioplasty ▪ Bypass graft ▪ Interposition graft ▪ Transposition ▪ Extremity amputation 				
	<u>Venous Disease</u> <ul style="list-style-type: none"> ▪ Diagnosis and medical therapy of aneurismal, obstructive, traumatic, neoplastic and infectious venous diseases ▪ Ligation, stripping and/or local removal of varicose veins ▪ Endoscopic or open ligation of incompetent perforator veins ▪ Catheter or open embolectomy/thrombectomy ▪ Resection with or without graft replacement ▪ Venoplasty ▪ Bypass graft ▪ Interposition graft ▪ Transposition 				

	<u>Miscellaneous</u> <ul style="list-style-type: none"> • Thoracic or lumbar sympathectomy • Surgical relief of thoracic outlet syndrome • Lymphedema surgery • Percutaneous vascular catheter placement • Arteriovenous fistula construction with or without synthetic graft material 				
	<u>Supplemental</u> <ul style="list-style-type: none"> ▪ Intravenous conscious sedation ▪ Diagnostic and therapeutic use of angiography equipment ▪ Percutaneous transluminal arterioplasty ▪ Atherectomy ▪ Endovascular stent and stent graft placement ▪ Descending thoracic aorta thoracoabdominal aortic surgery 				

I have requested and agree to perform only those operative procedures in the specific areas for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise at Teche Regional Medical Center. I also acknowledge that my professional malpractice insurance extends to all privileges I have requested, and attest to meeting the minimum qualifications having performed over 50 vascular procedures within the past 24-months.

Signature of Applicant

Date

Printed Name

I have reviewed the requested clinical privileges and supporting documentation and recommended the privileges 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