

**HOLY CROSS HOSPITAL  
CLINICAL PRIVILEGE REQUEST FORM**

**PRACTICE AREA: Anesthesia**

**DESCRIPTION:** A qualified anesthesia provider involved in the administration of anesthesia and related services as delineated by the clinical and non-clinical responsibilities described herein

**BASIC CRITERIA:**

Holds current New Mexico license.

Insured by an appropriate medical malpractice insurer for the limits required by the Board of Directors.

**CATEGORY 1:**

**Basic Education:** MD, DO, DDS, DMD

**Minimal Formal training:** Successful completion of a post graduate residency of at least three years duration.

Requested	Granted	Granted With Condition	Category 1	Type of Training		Number performed last 24 mos.	Estimated percent past complications	
				Residency	Other		morbidity	mortality
			Topical Anesthetics					
			Local Infiltration Anesthetics					
			Regional Nerve block for Surgery/procedure anesthesia					
			Regional Nerve block for pain management					

**Category II**

**Basic Education:** MD, DO, DMD, DDS

**Minimal Formal Training:** The applicant must demonstrate a completion of an approved three-year residency in anesthesia.

Requested	Granted	Granted With Conditions	category II	Type of Training		Number performed last 24 mos.	Estimated percent past complications	
				Residency	Other		morbidity	mortality
			Pre-anesthetic Assessment					
			Pre-anesthetic medication					
			General anesthesia and adjuvant drugs					
			Regional Anesthesia techniques					

Requested	Granted	Granted With Condition	category II	Type of Training		Number performed last 24 mos.	Estimated percent past complications	
				Residency	Other		morbidity	mortality
			Subarachnoid					
			Epidural					
			Caudal: Upper Extremity					
			Caudal: Lower Extremity					
			Periocular block					
			Transtracheal					
			Intra capsular					
			Intercostal					
			Conscious & deep sedation techniques					
			Perianesthesia management of patient					
			Cardiopulmonary resuscitation management					
			Perianesthetic invasive and noninvasive monitoring					
			Tracheal intubation/extubation					
			Mechanical ventilation/oxygen therapy					
			Fluid, electrolyte acid-base management					
			Blood, blood products, plasma extenders					
			Peripheral IV/arterial catheter placement					
			Central venous catheter placement					
			Acute & Chronic pain therapy					
			Postanesthesia care/release					

I understand that in making this request I am bound by the applicable Bylaws or policies of the hospital and thereby stipulate that I meet the threshold criteria for this request.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

I have reviewed the request for privileges above, and have made my recommendations as noted.

\_\_\_\_\_  
Department Chairman Signature

\_\_\_\_\_  
Date