

Applicant Name: \_\_\_\_\_

**Louisiana Medical Center and Heart Hospital**  
**Surgery Department**  
**Anesthesia**  
**Core Privilege Request Form**

Having reviewed the requirements for each set of privileges in the following pages, I would request the following privileges:

**Place a check mark in the appropriate box for each set of privileges. Please cross out any procedures that you will not be performing at this facility. All privileges will have a focused period of monitoring and if any privileges requested are not performed in this facility within the first 12 months, those privileges will not be renewed.**

**If you perform privileges which are not listed, please write them in, send in documentation that you have been trained on the procedure as well as how many you of the procedures have been done and where they were performed at.**

Privilege	Procedures	Requested	Not Requested
CORE I PRIVILEGES			
	<ul style="list-style-type: none"><li>-Local Anesthesia Infiltration</li><li>-Topical Application of Local Anesthesia</li><li>-Minor Nerve Blocks (dental, digital, wrist, ankle, etc.)</li><li>-Major Nerve Blocks (Branchial, Femoral, etc.)</li><li>-Intravenous Regional Anesthesia (Bier block)</li><li>-Brachial Plexus Blocks</li><li>-Intercostal Nerve Block</li><li>-Regional Anesthesia</li><li>-Invasive Monitoring</li><li>-Anesthetic and Surgical Manipulations</li><li>-Clinical Management of the Unconscious Patient</li><li>-Management of Pain Relief</li><li>-Management of Cardiopulmonary Resuscitation</li><li>-Application and Management of Specific Methods of Inhalation</li><li>-Management of various fluid, electrolyte, and metabolic disturbances.</li><li>-The supervision of CRNA's.</li></ul>		

**I attest by signature that I have met the minimum criteria of procedures/diagnoses management within my clinical practice for the procedures requested above, and I agree to provide documentation of said procedures/diagnoses management if requested.**

\_\_\_\_\_  
Applicant Signature Date

**The Department Chairperson accepts this applicant's attestation that he/she meets the minimum criteria for privileges requested.**

\_\_\_Yes \_\_\_No \_\_\_\_\_  
Department Chair Signature Date

Dear Physician:

Every physician seeking appointment/reappointment/advancement to Louisiana Heart Hospital & Medical Center is required to obtain annually 20 hours of AMA PRA Category 1 credit unless exempted. Physicians falling within any of the following categories are exempt from the 20 hour AMA PRA Category 1 requirement.

-  Initially licensed less than 1 year on the basis of examination;
-  Engaged in military service longer than one year's duration outside of Louisiana;
-  Certified or recertified within the past year by a member board of the American Board of Medical Specialties;
-  Currently in a residency training or fellowship.

Please submit copies of your CMEs that you have completed for the past two years.

Thank you,

Medical Staff Coordinator,  
Louisiana Medical Center and Heart Hospital