

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

Louisiana Medical Center and Heart Hospital  
Surgery Department  
**Vascular Surgery**

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
<b>CORE I PRIVILEGES</b>			
	-History & Physical Examinations -Major peripheral arterial reconstruction -Major peripheral venous reconstruction -Arterial or Venous Embolectomy -Arterial or Venous Thrombectomy -Carotid Endarterectomy -Aorta-Bifemoral Bypass -Femoral-Popliteal or Distal Artery Bypass -Placement of Vena Caval Filter -Surgery of the Thoracic outlet -Placement of Intra Arterial Graft and Stents -AAA Resection -PTA of Peripheral Arteries -Sympathectomy – Thoracic (Dorsal) & Lumbar -Operative Arteriography, Venography		
<b>NON-CORE PRIVILEGES</b> – for vascular imaging privileges, see the Peripheral Vascular Diagnostic delineation list.			
<b>MODERATE SEDATION</b> <i>(Contact the Medical Staff Office)</i>			

**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

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

Louisiana Medical Center and Heart Hospital  
**Peripheral Vascular Diagnostic & Interventional Procedures**

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. Cross out any procedures not currently performed in your clinical practice.*

Privilege	Procedures	Requested	Not Requested
<b>CORE I - Peripheral Vascular</b>			
	-PTA, Stents, Atherectomy, Catheter Thrombectomy in lower extremities and brachiocephalic vessels		
<b>CORE II – Peripheral Intervention</b>			
	-Visceral segments (renal arteries and mesenteric vessels) -Thrombolytic therapy including catheter-directed thrombectomy -Coil embolization -Caval filter placement		
<b>CORE III a – Diagnostic Neurovascular &amp; Extra-cranial Carotid Angiography &amp; Endovascular Interventions</b>			
	-CNS Diagnostic -Extracranial Carotid Diagnostic		
<b>CORE III b – Diagnostic Neurovascular &amp; Extra- cranial Carotid Angiography &amp; Endovascular Interventions</b>			
	-Extracranial Carotid PTA/Stent		
<b>CORE IV – Endograft Section</b>			
	-Vascular Endografts		
<b>Peripheral Vascular Non-Invasive Lab Privileges</b>			

**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