

**REHOBOTH MCKINLEY CHRISTIAN HOSPITAL  
CLINICAL PRIVILEGES APPLICATION**

**ANESTHESIA**

APPLICANT NAME: \_\_\_\_\_

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**CORE PRIVILEGES:**

Anesthesia privileges include being able to perform local infiltration anesthesia, topical application, nerve blocks, conscious sedation, general and regional anesthesia. The core privileges also include pre-anesthesia assessment; intra-operative management of airway, fluid, electrolyte, acid-base, blood, blood products, plasma expanders; intra-operative monitoring of vital life functions and organs; post-anesthesia care and/or discharge; and cardiopulmonary resuscitation management.

**The core privileges do not include any privilege listed under Special Privileges.**

**NOTE: In the case of an emergency, to the degree permitted by license and regardless of department, staff status or clinical privileges, shall be permitted and shall be assisted by hospital personnel to do everything possible to save a patient from serious harm.**

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**QUALIFICATIONS FOR CORE PRIVILEGES:** (Check only the first one which applies to you)

**CLASS IV:**

\_\_\_ Completion of or certification in from an Accreditation Council for Graduate Medical Education (ACGME)- or American Osteopathic Association (AOA)- approved sub-specialty fellowship in Anesthesiology.

Sub-specialty: \_\_\_\_\_

Members with these privileges are expected to be physicians with experience, training and competence of service as consultants and treating the most extreme illnesses within the subspecialty area.

**CLASS III:**

\_\_\_ Board certification in Anesthesiology; or  
\_\_\_ Active board certification application pending in Anesthesiology, having completed an ACGME- or AOA-approved post graduate training program in Anesthesiology, with ACLS certification; or

\_\_\_ Completion of an ACGME- or AOA-approved post graduate training program and full time anesthesiology experience for a minimum of the last four (4) years consecutively, with ACLS certification.

Members with these privileges are expected to be physicians with experience, training and competence in their specialty. Such physicians would be expected to request consultation: (1) when

hazardous treatment procedures are contemplated; (2) when unexpected complications arise; (3) or in cases in which treatment response seems unduly delayed.

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ANESTHESIA PRIVILEGES APPLICATION

NAME: \_\_\_\_\_

**CLASS II:**

- \_\_\_ At least a two year completion of an ACGME- or AOA-approved post graduate training program in Anesthesiology, with ACLS certification; or
- \_\_\_ Completion of an AANA Council on Accreditation of Nurse Anesthesia Education Programs-approved program of at least 24 months duration, with ACLS certification.

Members with these privileges are required to request consultation in all cases in which doubt exists as to the diagnosis, or in cases in which treatment is not too soon apparent. Illness or problems requiring skills usually acquired during post internship specialty training.

Other training, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SPECIAL PRIVILEGES:** For each special request, you must state the training and number of procedures during training; or number of procedures performed in the last 12 months. If any one or all special privileges are not needed, YOU MUST CHECK "NO" UNDER "PRIVILEGES REQUESTED".

PRIVILEGES

PRIVILEGES

REQUESTED

RECOMMENDED

YES NO

YES NO

\_\_\_ \_\_\_ Management of acute pain relief by regional analgesia/anesthesia.

\_\_\_ \_\_\_

Training/Experience: \_\_\_\_\_

\_\_\_ \_\_\_ Management of chronic pain relief by regional analgesia/anesthesia.

\_\_\_ \_\_\_

Training/Experience: \_\_\_\_\_

\_\_\_ \_\_\_ Swan Ganz catheter placement.

\_\_\_ \_\_\_

Training/Experience: \_\_\_\_\_

\_\_\_ \_\_\_ Arterial line placement.

\_\_\_ \_\_\_

Training/Experience: \_\_\_\_\_

\_\_\_ \_\_\_ Central venous catheter placement.

\_\_\_ \_\_\_

Training/Experience: \_\_\_\_\_

\_\_\_ \_\_\_ Anesthesia for renal dialysis access procedures

\_\_\_ \_\_\_

ADDITIONAL PRIVILEGES (Specify, stated with training/experience):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_ \_\_\_

\_\_\_ \_\_\_

ANESTHESIA PRIVILEGES APPLICATION

NAME: \_\_\_\_\_

APPLICANT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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DEPARTMENT REVIEW:

Comments/Recommendations/Suggestions:

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Signed: \_\_\_\_\_  
Department Chairperson

\_\_\_\_\_  
Date of Review

SURGERY DEPARTMENT.  
Medical Staff Department

MSS: 09/99.