

CARLSBAD MEDICAL CENTER

GENERAL SURGERY APPLICATION FOR PRIVILEGES

NAME OF APPLICANT: _____

BOARD CERTIFICATION: _____

DATE OF CERTIFICATION: _____

Privileges in General Surgery are granted for both clinical cognitive areas and specific procedures. All practitioners requesting General Surgery privileges are to be board certified by the American Board of General Surgery or by the American Osteopathic Board of General Surgery, or must be fully trained in an accredited General Surgery residency program recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

CHECK EACH AREA FOR WHICH YOU ARE REQUESTING PRIVILEGES:

R = Requested G = Granted D = Denied

GENERAL COGNITIVE PRIVILEGES

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Admitting and Attending Privileges |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assisting in Surgery Only |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consultation Only |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Critical Care Admission and Management |

PRIVILEGE LEVEL	PROCEDURAL PRIVILEGES
Level 1	USUAL AND CUSTOMARY GENERAL SURGERY PROCEDURAL PRIVILEGES 1) These procedural privileges are usually and customarily performed by board certified, board eligible or fully trained General Surgeons; and 2) Documentation of specific training and/or experience in Level 1 procedural privileges may be required; and 3) Level 1 procedural privileges are unasterisked.

PRIVILEGE LEVEL	PROCEDURAL PRIVILEGES
Level 2	ADVANCED GENERAL SURGERY PROCEDURAL PRIVILEGES 1) These procedural privileges may be performed by board certified, board eligible or fully trained General Surgeons; and 2) Level 2 procedural privileges require documentation of training and experience; and 3) Individual Level 2 procedural privileges must be proctored as defined on this privilege delineation form; and 4) Level 2 procedural privileges are denoted by * (one asterisk).

CARLSBAD MEDICAL CENTER –REQUEST FOR PRIVILEGES – GENERAL SURGERY

Name of Applicant: _____

R = Requested G = Granted D = Denied

NOTE: If applying for an asterisked () privilege, enter the number and location of procedures performed in the last 2 years.*

R	G	D		# Performed	Location Performed
SURGICAL PROCEDURES					
ANESTHESIA PROCEDURES					
CONSCIOUS SEDATION					
[]	[]	[]	Pediatric (<15 years) Moderate Sedation*	_____	_____
[]	[]	[]	Adult Moderate Sedation*	_____	_____
[]	[]	[]	Pediatric (<15 years) Deep Sedation*	_____	_____
[]	[]	[]	Adult Deep Sedation*	_____	_____
ABDOMINAL & GASTROINTESTINAL					
[]	[]	[]	Abdominoperineal Resection		
[]	[]	[]	Anoplasty		
[]	[]	[]	Appendectomy		
[]	[]	[]	Anal Fistulectomy		
[]	[]	[]	Colon Resection, with or without Enterostomy		
[]	[]	[]	Drainage of Major Abscess		
[]	[]	[]	Enterolysis		
[]	[]	[]	Exploratory Laparotomy		
[]	[]	[]	Gastric Procedures		
[]	[]	[]	Hemorrhoidectomy		
[]	[]	[]	Hiatal Hernia Repair, Anti-Reflux Procedures		
[]	[]	[]	Laparotomy		
[]	[]	[]	Paracentesis		
[]	[]	[]	Peritoneal Dialysis Catheter Placement		
[]	[]	[]	Pilonidal Cyst Excision		
[]	[]	[]	Pyloromyotomy		
[]	[]	[]	Pyloroplasty with Vagotomy		
Repair of Hernia:					
[]	[]	[]	Diaphragmatic		
[]	[]	[]	Femoral		
[]	[]	[]	Inguinal		
[]	[]	[]	Umbilical		
[]	[]	[]	Ventral		
[]	[]	[]	Retroperitoneal Exploration		
[]	[]	[]	Small Bowel Resection		
[]	[]	[]	Splenectomy		
[]	[]	[]	Transanal Excision of Neoplasm or Other Lesion		
BREAST					
[]	[]	[]	Axillary Node Dissection		
[]	[]	[]	Biopsy		
Mastectomy:					
[]	[]	[]	Partial		
[]	[]	[]	Complete		

CARLSBAD MEDICAL CENTER –REQUEST FOR PRIVILEGES – GENERAL SURGERY

Name of Applicant: _____

R	G	D		# Performed	Location Performed
CARDIOLOGY					
[]	[]	[]	Arterial Lines – Peripheral*	_____	_____
[]	[]	[]	Central Venous Lines	_____	_____
[]	[]	[]	Swan Ganz Catheterization*	_____	_____
ESOPHAGUS					
[]	[]	[]	Anastomosis		
[]	[]	[]	Dilatation		
[]	[]	[]	Varices Ligation, Sclerosis		
[]	[]	[]	Esophagomyotomy (Heller Procedure)		
[]	[]	[]	Esophagotomy		
GYNECOLOGY					
[]	[]	[]	Oophorectomy		
HEAD & NECK					
[]	[]	[]	Branchial Cleft Cyst, Sinus Excision		
[]	[]	[]	Excision Submaxillary Gland		
[]	[]	[]	Eyelid Trauma Repair		
[]	[]	[]	Parathyroidectomy		
[]	[]	[]	Parotidectomy		
[]	[]	[]	Thyroid Needle Biopsy		
[]	[]	[]	Thyroidectomy		
[]	[]	[]	Thyroglossal Duct Cyst Excision		
[]	[]	[]	Tracheostomy		
LIVER, BILIARY TRACT, PANCREAS					
[]	[]	[]	Cholecystectomy		
[]	[]	[]	Choledocoenterostomy		
[]	[]	[]	Cholecystostomy		
[]	[]	[]	Hepatojejunostomy		
[]	[]	[]	Hepatic Lobectomy*	_____	_____
[]	[]	[]	Hepatic Wedge Resection		
[]	[]	[]	Liver Biopsy		
[]	[]	[]	Pancreas Biopsy		
[]	[]	[]	Pancreatectomy*	_____	_____
[]	[]	[]	Transduodenal Sphincteroplasty		
ORTHOPEDICS					
[]	[]	[]	Amputation		
SKIN, SUBCUTANEOUS TISSUE, AND MUSCLE					
[]	[]	[]	Biopsy		
[]	[]	[]	Burn Treatment (< 20% Total Body Surface)		
[]	[]	[]	Excision		
[]	[]	[]	Excision Lymph Nodes		
[]	[]	[]	Fasciotomy		
			Graft:		
[]	[]	[]	Split Thickness		
[]	[]	[]	Full Thickness*	_____	_____
[]	[]	[]	Incision and Drainage		
[]	[]	[]	Secondary Wound Closure		
[]	[]	[]	Wound Repair		

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THORACIC

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thorascopy*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thoracostomy	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thoracotomy	_____	_____

UROLOGY

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circumcision		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hydocele		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orchiectomy		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suprapubic Catheterization		

VASCULAR, LYMPHATIC AND NEURAL

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arterial Bypass Grafts:	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intra-Abdominal*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carotid-Subclavian*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Embolectomy		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arterial*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Graft*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venous*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endarterectomy		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carotid*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intra-Abdominal*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intraoperative Angiography		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Venous Procedures		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shunts:		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arterial-Venous		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Portal Systemic Venous*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sympathectomy:		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumbar		

OTHER MODALITIES

ENDOSCOPIC PROCEDURES

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchoscopy:		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flexible*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rigid	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Choledochoscopy*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colonoscopy*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laryngoscopy		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mediastinoscopy*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Percutaneous Endoscopic Gastrostomy Tube		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insertion		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sigmoidoscopy		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Gastrointestinal Endoscopy		

LAPAROSCOPIC PROCEDURES

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Diagnostic*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anti-Reflux Procedure*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cholecystectomy*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia Repair*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopic-Assisted Colon Resection*	_____	_____

GENERAL SURGERY
CRITERIA FOR CLINICAL PRIVILEGES

Privileges followed by an asterisk (*) are identified in this table. Please submit required documentation when applicable at the time of appointment or reappointment. The numbers indicated in this table represent the minimal number of documented procedures to be submitted for consideration of the advanced privilege requested. Additional documentation of training, experience and/or current competence may be requested and additional proctoring may be requested at any time by the Department Chairperson, or the Medical Staff Executive Committee for any privilege requested.

PROCEDURES	TRAINING/EXPERIENCE	Number of Documented Procedures for Initial Appointment	Number of Procedures Every 2 Years	Number of Procedures to be Initially Proctored	
ANESTHESIA					
Conscious Sedation – Pediatric (<15 years) Moderate Sedation or Analgesia	See Attachment C	2	1	N/A	
Conscious Sedation – Adult Moderate Sedation or Analgesia	See Attachment C	2	1	N/A	
Conscious Sedation – Pediatric (<15 years) Deep Sedation or Analgesia	See Attachment C	2	1	4	
Conscious Sedation – Adult deep Sedation or analgesia	See Attachment C	2	1	4	
CARDIOLOGY					
Arterial Lines- Peripheral	Documentation of Successful Performance	10	2	1	
Swan Ganz Catherization	Documentation of Successful Performance	10	2	1	
LIVER, BILIARY TRACT, PANCREAS					
Hepatic Lobectomy	Documentation of Successful Performance	2	N/A	N/A	
Pancreatectomy	Documentation of Successful Performance	2	N/A	N/A	
SKIN, SUBCUTANEOUS TISSUE, AND MUSCLE					
Full Thickness Grafting	Documentation of Successful Performance	2	1	N/A	
THORACIC					
Thorascopy	Documentation of Successful Performance	2	2	1	
VASCULAR					
Intra-abdominal Arterial Bypass Graft	Documentation of Successful Performance	2	1	1	
Lower Extremity Arterial Bypass Graft		Documentation of Successful Performance	2	1	N/A
Upper Extremity Arterial Bypass Graft			2	1	1
Carotid/Subclavian Arterial Bypass Graft			2	1	1
Arterial Embolectomy	Documentation of Successful Performance	1	1	N/A	
Graft Embolectomy		2	2	1	
Venous Embolectomy		1			
Carotid Endarterectomy	Documentation of Successful Performance	1	2		1
Intra-abdominal Endarterectomy		1			
Peripheral Endarterectomy		1			
Portal Systemic Venous Shunt	Documentation of Successful Performance	2	N/A	N/A	

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PROCEDURES	TRAINING/EXPERIENCE	Number of Documented Procedures for Initial Appointment	Number of Procedures Every 2 Years	Number of Procedures to be Initially Proctored
ENDOSCOPIC PROCEDURES				
Flexible Bronchoscopy	Documentation of Successful Performance	2	2	N/A
Choledochoscopy	Documentation of Training in Residency or Fellowship in Endoscopic Procedures or Through an Approved Course, and Demonstration of Successful Performance in Each Type	2	1	1
Colonoscopy		2	1	1
Mediastinoscopy		2	1	1
LAPAROSCOPIC PROCEDURES				
Abdominal Diagnostic	Documentation of Training in Residency or Fellowship in Laparoscopic Procedures or Through an Approved Course, and Demonstration of Successful Performance in Each Type	2	N/A	N/A
Appendectomy		2	N/A	N/A
Anti-Reflux Procedure		2	1	1
Cholecystectomy		5	2	N/A
Hernia Repair		2	2	1
Laparoscopic-Assisted Colon Resection		2	2	1

MEDICAL STAFF CREDENTIALING CRITERIA FOR CONSCIOUS SEDATION

Moderate Sedation or Analgesia

Separate privileges are granted for the categories of adult and pediatric (< 15 years) moderate sedation or analgesia, based on documentation of current competency.

All medical staff requesting any conscious sedation privilege must complete and document a review of the current medical staff conscious sedation policy. **In addition** to the required review of the conscious sedation policy, practitioners requesting privileges in conscious sedation must meet requirements of either #1 **or** #2 listed below:

1. Documentation of training, experience and current competence related to the use of moderate sedation or analgesia, **and** successful performance of at least (1) moderate sedation/analgesia case in the last (2) years for each category of moderate sedation or analgesia applied for and (2) sedation/analgesia cases at initial appointment **OR**
2. Documentation of relevant training and experience **AND**
 - a. Attendance at a Carlsbad Medical Center sponsored CME program on moderate sedation/analgesia **or** review of the videotape of such conference **and** achievement of a score of 85% or higher on the moderate sedation/analgesia post-test, **AND** provisional privileges will be granted pending outcome review.

Deep Sedation or Analgesia

Separate privileges to be granted for the categories of adult and pediatric (< 15 years) deep sedation or analgesia based on documentation of current competency. **All** medical staff requesting any conscious sedation privilege, must complete and document a review of the current medical staff conscious sedation policy **AND** maintain current ACLS certification (*PALS or NALS as appropriate*); **OR** be Board Certified or fully trained in a Carlsbad Medical Center approved residency training program in Emergency Medicine, Anesthesiology or Critical Care Medicine.

In addition to the required review of the conscious sedation policy, ACLS and board certification or residency requirements above, practitioners requesting privileges in conscious sedation must meet requirements of either #1 **or** #2 listed below:

1. Documentation of training, experience and current competence related to use of deep sedation/analgesia, **and** successful performance of at least (1) deep sedation/analgesia cases in the last (2) years for each category of deep sedation or analgesia applied for **OR**
2. Documentation of relevant training and experience, **AND ALL** of the following:
 - a. Attendance at a Carlsbad Medical Center-sponsored CME program on deep sedation/analgesia or review of the videotape of such conference and achievement of the score of 85% or higher on the deep sedation/analgesia post-test, **AND**
 - b. Provide documentation of successful completion of four (4) deep sedation/analgesia cases, in each category applied for, under the direct supervision of a Carlsbad Medical Center practitioner holding appropriate clinical privileges in deep sedation. If applying for both categories of deep sedation/analgesia, a total of six (6) cases will satisfy this requirement **AND**
 - c. Successful completion of four (4) intubations in the Operating Room under the direct supervision of a Carlsbad Medical Center credentialed anesthesiologist. If applying for both categories of deep sedation/analgesia, a total of six (6) cases will satisfy this requirement.



AUTHORIZATION FOR BACKGROUND CHECK

By signing below, I grant permission to the Hospital, its medical staff and representatives ("Hospital") to obtain an investigative report, to include state and federal criminal records and driving arrest records, for purposes of processing my medical staff application. I understand that I may request the Hospital to disclose the nature and scope of the investigation requested within five (5) days of my written request made within a reasonable time after the Hospital obtains the information. I also understand that I am entitled to request a summary of my rights with respect to consumer reporting agencies.

Print Name

Signature

Date