

**CARLSBAD MEDICAL CENTER
APPLICATION FOR CLINICAL PRIVILEGES
DEPARTMENT OF SURGERY: VASCULAR**

NAME: _____ DATE: _____

Life threatening emergency: At the time of a clinical emergency, any practitioner may render whatever care he/she believes to be indicated.

Documented number of cases as well as letter of recommendation of non-cardiothoracic vascular surgery from program director required before privileges will be granted.

Illness or problem requiring skills usually acquired during post-internship specialty training, or as a consequence of experience.

Requested	Granted	
___	___	Vein stripping and ligation
___	___	Ligation and/or division peripheral vein, except varicose
___	___	Excision and ligation varicose veins

Complex or severe illness or problem and those with immediate or serious threat to life, requiring skills usually achieved only during training sufficient to attain qualification for board certification.

Requested	Granted	
___	___	Embolectomy
___	___	Thrombectomy
___	___	Vena cava plication and clipping and complete interruption
___	___	Excision and/or ligation peripheral artery
___	___	Operations on arteriovenous fistula, peripheral
___	___	Anastomosis and other repair, peripheral
___	___	Radical excision lymphatic structures
___	___	Suture ligation – blood vessels, head, neck
___	___	Repair or vascular injuries
___	___	Hemodialysis access
___	___	Sympathectomy lumbar

Illness or problem requiring an unusual degree of expertise or competence in techniques requiring special skills, usually acquired only with experience or subspecialty training. Vascular board certified required, or Board qualified within the time limits of the American Board of Vascular Surgery or the American Osteopathic Board of Vascular Surgery, or extensive peripheral vascular experience documented during cardiothoracic surgery residency.

Those privileges marked with an * require documentation of training and/or experience in addition to board certification or qualification in the requested subspecialty. (See attached documentation requirements)

Requested	Granted	
___	___	Aneurysmectomy, abdominal and peripheral
___	___	Bypass arterial surgery
___	___	Porto-systemic shunts
___	___	Reconstruction, peripheral artery by graft
___	___	Endarterectomy, abdominal
___	___	Reconstruction intra-abdominal artery by blood vessel
___	___	Aortic-iliac, aorto-femoral bypass grafts, femoral grafts, axillafemoral grafts
___	___	Femoral bypass procedures
___	___	Popliteal bypass procedures
___	___	Tibial bypass procedures
___	___	Other vascular procedures on abdomen or extremities
___	___	Endarterectomy, abdominal, iliac and femoral vessels
___	___	Arteriography, percutaneous
___	___	Arteriography, incision

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Requested	Granted	
___	___	Renal-arterial surgery
___	___	Endarterectomy, carotid and peripheral
___	___	Abdominal, peripheral arterial or venous ballon angioplasty
___	___	*Stent placement

APPLICANT'S SIGNATURE: _____ DATE: _____

Specific privileges denied: ___ ___
Yes No

If yes, please comment: _____

REVIEWED BY: _____ DATE: _____
 TITLE: _____

Procedure	Course	
Stent placement	X	



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