

CARLSBAD MEDICAL CENTER

ANESTHESIOLOGY APPLICATION FOR PRIVILEGES

NAME OF APPLICANT: _____

BOARD CERTIFICATION: _____ DATE: _____

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

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

CHECK EACH AREA FOR WHICH YOU ARE REQUESTING PRIVILEGES:

R = Requested G = Granted D = Denied

GENERAL COGNITIVE PRIVILEGES

R	G	D		# Performed	Location Performed
[]	[]	[]	Admitting Privileges for Chronic Pain Management*		
[]	[]	[]	Pre-op Consultations and Assessment		
[]	[]	[]	Consultations for Chronic Pain Management*		
[]	[]	[]	Post Operative Acute Pain Management		

PRIVILEGE LEVEL	PROCEDURAL PRIVILEGES
Level 1	USUAL AND CUSTOMARY ANESTHESIOLOGY PROCEDURAL PRIVILEGES 1) These procedural privileges are usually and customarily performed by board certified, board eligible or fully trained Anesthesiologist; 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 ANESTHESIOLOGY PROCEDURAL PRIVILEGES 1) These procedural privileges may be performed by board certified, board eligible or fully trained Anesthesiologist; 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 -- Anesthesiology

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
GENERAL PROCEDURES					
[]	[]	[]	Double Lumen Intubation		
[]	[]	[]	Endotracheal Intubation		
[]	[]	[]	Fiberoptic Endotracheal Intubation		
[]	[]	[]	Monitoring of Anesthesia Care		
GENERAL ANESTHESIA					
[]	[]	[]	Inhalation Anesthesia		
[]	[]	[]	Intravenous Anesthesia		
[]	[]	[]	Hypotensive Anesthesia		
REGIONAL ANESTHESIA					
[]	[]	[]	Bier Blocks		
[]	[]	[]	Brachial Plexus Block		
[]	[]	[]	Epidural Anesthesia		
[]	[]	[]	Intercostal Nerve Block		
[]	[]	[]	Intravenous Regional Anesthesia		
[]	[]	[]	Peripheral Nerve Blocks		
[]	[]	[]	Subarachnoid Anesthesia		
[]	[]	[]	Topical and Infiltration as in Field Blocks		
INVASIVE PROCEDURES AND MONITORING					
[]	[]	[]	Arterial Line- Peripheral		
[]	[]	[]	Central Venous Line		
[]	[]	[]	Swan Ganz Catheterization*	_____	_____
MAJOR SURGERY TYPES					
[]	[]	[]	Endoscopy		
[]	[]	[]	Gynecology		
[]	[]	[]	Head and Neck		
[]	[]	[]	Intra-Abdominal		
[]	[]	[]	Intra-Thoracic		
[]	[]	[]	Orthopedic		
[]	[]	[]	Pediatric		
[]	[]	[]	Vascular		
PAIN MANAGEMENT					
[]	[]	[]	Differential Nerve Blocks		
[]	[]	[]	Nerve Blocks		
[]	[]	[]	Epidural Blocks		
[]	[]	[]	Spinal Blocks		
[]	[]	[]	Facet Blocks*		
[]	[]	[]	Post Operative Pain Management	_____	_____

CARLSBAD MEDICAL CENTER –REQUEST FOR PRIVILEGES -- Anesthesiology

Name of Applicant: _____

R	G	D		#	
				Performed	Location Performed

OTHER PROCEDURES

[]	[]	[]	Specify: _____	*	_____	_____
[]	[]	[]	Specify: _____	*	_____	_____

I certify that I have had the necessary training and experience to perform the procedures that I have requested.

NAME OF APPLICANT (Please Print)

SIGNATURE

DATE

APPROVALS

All privilege delineations have been individually considered and have been recommended based upon the practitioner's specialty, licensure, specific training, experience, health status, current competence and peer recommendations.

APPLICANT MAY PERFORM PRIVILEGES AND PROCEDURES AS INDICATED:

EXCEPTIONS/LIMITATIONS:

(specify)

Surgery Department Chairperson

Date

Medical Executive Committee

Date

Board of Trustees

Date

Name of Applicant: _____

ANESTHESIOLOGY
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 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
COGNITIVE PRIVILEGES				
Admitting Privileges for Chronic Pain Management	Documentation of Successful Performance	N/A	N/A	N/A
Consultation for Chronic Pain Patients	Documentation of Successful Performance	N/A	N/A	N/A
INVASIVE PROCEDURES				
Swan Ganz Catheterization	Documentation of Successful Performance	10	2	1
PAIN MANAGEMENT				
Facet Blocks	Documentation of Successful Performance or Certification of Training and Proficiency by a Residency Program	2	1	1



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