

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

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 from program director required before privileges will be granted.

Illness or problem with no serious threat to life.

THORACIC

Requested	Granted	
___	___	Chest tube placement
___	___	Thoracentesis

CARDIAC SURGERY WITHOUT CP BYPASS

Requested	Granted	
___	___	Closed chest cardiac massage
___	___	Electric defibrillation- countershock, cardioversion
___	___	Auto-transfusions

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

THORACIC

Requested	Granted	
___	___	Exploratory thoracotomy
___	___	Operations of diaphragm and chest wall
___	___	Rib resection
___	___	Wedge resection - lung

CARDIAC SURGERY WITHOUT CP BYPASS

Requested	Granted	
___	___	Open cardiac massage

Criteria for requesting privileges includes significant training in and experience in the care of these conditions requiring skills usually achieved only during training sufficient to attain qualification for board certification in cardiovascular surgery.

THORACIC

Requested	Granted	
___	___	Tumor of lung, chest wall and pleura; mediastinal structures
___	___	Phrenic nerve surgery
___	___	Heller myotomy
___	___	Drainage lung abscess
___	___	Segment resection
___	___	Lobectomy
___	___	Pneumonectomy
___	___	Esophageal resection
___	___	Hiatal hernia repair/Gastroesophageal reflux repair
___	___	Mediastinal tumor resection

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ENDOSCOPY

Requested	Granted	
___	___	Esophagoscopy

CARDIAC SURGERY WITHOUT CP BYPASS

Requested	Granted	
___	___	Pericardiectomy

CARDIAC

Requested	Granted	
___	___	Pericardiocentesis

OTHER

Requested	Granted	
___	___	Conscious sedation

Illness or problem requiring an unusual degree of expertise or competence in techniques requiring special skills, usually acquired only with experience or subspecialty training. Board certified in subspecialty requested, or Board qualified within the current time limits of the American Board of Cardiovascular Surgery.

* Those privileges marked with an * require documentation of training and/or experience in addition to board Certification or qualification in the requested subspecialty.

** Privileges not listed below will not be granted until the development of procedure specific criteria.

THORACIC

Requested	Granted	
___	___	Repair vascular injuries; i.e., carotid, subclavian innominate, thoracic aortas
___	___	Chest wall resection and reconstruction

ENDOSCOPY

Requested	Granted	
___	___	Mediastinoscopy (with or without biopsy)
___	___	Bronchoscopy
___	___	Thoracoscopy

CARDIAC SURGERY WITHOUT CP BYPASS

Requested	Granted	
___	___	Extracardial surgery – patent ductus, coarctation of aorta, surgery not requiring cardio-pulmonary bypass
___	___	Pacemaker implantation, transvenous, temporary, and permanent
___	___	Pacemaker implantation, transthoracic and subxyphoid
___	___	Pacemaker implantation, epicardial and subxyphoid
___	___	Vena Caval filter insertion
___	___	AICD placement – automatic implantable cardioverter defibrillator

CARDIAC SURGERY WITH CP BYPASS

Requested	Granted	
___	___	IAPB, insertion of
___	___	PDA
___	___	Coarctation
___	___	Atrial septal defect

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Requested	Granted	
___	___	CABG
___	___	Valve replacement
___	___	Ventricular aneurysm
___	___	Thoracotomy
___	___	Repair ascending aortic aneurysm
___	___	Repair descending aortic aneurysm
___	___	Repair post-aortic aneurysm

APPLICANT'S SIGNATURE: _____ DATE: _____

Specific privileges denied:
 Yes No

If yes, please comment: _____

REVIEWED BY: _____
TITLE: _____ DATE: _____



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