DEPARTMENT OF SURGERY
CARDIOVASCULAR-THORACIC SECTION

Privilege Request Form

Applicant's Name: _____

(Please Print)

DIRECTIONS: This Privilege Request Form must accompany all initial applications for appointment to the Cardiovascular-Thoracic Section, Department of Surgery. Please indicate those privileges that apply to your surgical practice.

CATEGORY I: GENERAL ADMISSION & CLINICAL CARE

Privileges Requested: ❑ All ❑ Partial (as checked below)

_____ Conditions of mild degree
_____ Conditions of moderate severity
_____ Conditions of severe degree
_____ Myocardial infarction and complications
_____ Valvular heart disease
_____ Unstable angina pectoris
_____ Cardiovascular trauma
_____ Congenital heart disease
_____ Infectious endocarditis
_____ *Other: (specify)
_____

_____ Heart block/arrhythmia
_____ Lung cancer
_____ Lung abscess
_____ Pulmonary emboli
_____ Pneumothorax
_____ Blunt/penetrating chest trauma
_____ Esophageal carcinoma
_____ Esophageal stricture
_____ Esophageal perforation

***Additional procedures require consideration/approval of the Department.**

CATEGORY II: MODERATE COMPLEXITY

Privileges Requested: ❑ All ❑ Partial (as checked below)

_____ Pericardiocentesis
_____ Insertion of chest tube
_____ Placement of Swan-Ganz catheter
_____ Suture laceration
_____ Thoracentesis
_____ Wound aspiration
_____ Needle biopsy, lung or thoracic mass
_____ Mediastinotomy
_____ Mediastinoscopy
_____ Arteriography
_____ Peripheral balloon angioplasty
_____ *Other: (specify)
_____

_____ Peripheral stent placement
_____ Bronchoscopy
_____ Esophagoscopy
_____ Embolectomy
_____ Pericardiocentesis
_____ Rib resection for drainage
_____ Open lung biopsy
_____ Transbronchial biopsy
_____ Transvenous pacemaker placement
_____ Pericardial biopsy/window

***Additional procedures require consideration/approval of the Department.**

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CATEGORY III. MAJOR COMPLEXITY

Category III Privileges Requested: ❑ All ❑ Partial (as checked below)

A. CARDIAC SURGERY

_____ Transthoracic placement of pacemaker
_____ Pericardiectomy
_____ Repair of Congenital anomalies
  _____ with cardiopulmonary bypass
  _____ without cardiopulmonary bypass
_____ Valve repair or replacement
_____ Ascending aortic aneurysm
_____ Dissecting aneurysm
_____ Repair of ventricular aneurysm
_____ Coronary artery bypass graft
_____ Repair of cardiovascular injury
_____ Insertion of balloon counter pulsation device
_____ Placement of ventricular assist device with device-specific qualification
_____ Transmyocardial revascularization

_____ *Other: (specify)
_____

B. THORACIC SURGERY

_____ Repair of chest wall deformity
_____ Exploratory thoracotomy
_____ Thoracotomy for hemorrhage
_____ Pulmonary resection
_____ Decortication
_____ Thoracotomy for mediastinal tumor
_____ Thoracoplasty
_____ Tracheal reconstruction
_____ Esophageal resection
_____ Esophageal bypass
_____ Pulmonary embolectomy
_____ Resection of chest wall mass
_____ Video-assisted thoracoscopy

_____ *Other: (specify)
_____

C. VASCULAR SURGERY

_____ Aneurysm surgery (open repair/resection)
_____ Arterial anastomosis, extra thoracic
_____ Arterial bypass grafts, extremities
_____ Carotid artery surgery
_____ Ligation/division/excision of varicose veins
_____ Peripheral angioplasty
_____ Percutaneous peripheral vascular interventions
_____ Sympathectomy
_____ Vena caval interruption procedures
_____ Venous anastomosis

_____ *Other: (specify)
_____

***Additional procedures require consideration/approval of the Department.**

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CATEGORY IV. ADVANCED PROCEDURES/NEW TECHNOLOGY

_____ Aortic stent graft
_____ *Other: (specify)
_____

***Additional procedures require consideration/approval of the Department.**

_____ Laser surgery
_____ Yes*
_____ No

*Must complete separate Laser Privilege Request form.

_____ _____
Applicant's Signature *Date*

Cardiovascular Thoracic Section
Privilege Request Form

Applicant's Name: _____

(Please Print)

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For Office Use Only

Recommendations:
( ) Approve as requested.
( ) Approve with modifications as noted below.
( ) Denial of privileges.

Modifications:

_____

_____

_____

I (we) attest that in recommending these privileges, due consideration has been given to the applicant's professional performance, training, experience, judgment, and technical skills.

Observers

_____

_____

_____ _____

Chairman, Cardiovascular-Thoracic Section *Date*

_____ _____

Chairman, Department of Surgery *Date*

_____ _____

Co-Chief of Professional Staff *Date*
(if requesting interim privileges)

Action:

Credentials Committee Date: _____

Professional Staff Executive Committee Date: _____

Board of Trustees Date: _____

McLAREN GREATER LANSING

LASER PRIVILEGE REQUEST FORM

Applicant's Name: _____
(Please Print)

Specialty: _____

Instructions: Please complete this form and submit it to the Medical Staff Services Department with appropriate documents. **Note:** Prior or concurrent approval of the applicable associated clinical procedure(s)/privilege(s) is a pre-requisite for a favorable recommendation on a request for laser privileges.

Type of laser wave length available at McLaren Greater Lansing for which you are requesting privileges:

CO_2 Laser
____ Endoscopy
____ Laparoscopy
____ Open surgical
____ Arthroscopy

ND: YAG Laser
____ Endoscopy
____ Laparoscopy
____ Open surgical
____ Arthroscopy
____ Intravascular

ND: YAG Ophthalmic Laser
____ Q Switched
____ Contact

____ **Holmium YAG Laser**

Pulsed Dye Laser
____ Arthroscopy

____ **Excimer Laser**

____ **GreenLight PVP Laser**

Physics and safety lecture attended: _____ Date: _____

_____ _____
Applicant's Signature *Date*

****

For Office Use Only

Recommendations:
( ) Approve as requested.
( ) Approve with modifications as noted below.
( ) Denial of privileges.

Modifications: _____

_____

I (we) attest that in recommending these privileges, due consideration has been given to the applicant's professional performance, training, experience, judgment, and technical skills.

_____ _____
Chairman, Cardiovascular-Thoracic Section *Date*

_____ _____
Chairman, Department of Surgery *Date*

_____ _____
Co-Chief of Professional Staff (if requesting interim privileges) *Date*

Action:
Credentials Committee Date: _____
Professional Staff Executive Committee Date: _____
Board of Trustees Date: _____