LAC+USC MEDICAL CENTER & HEALTHCARE NETWORK ATTENDING STAFF ASSOCIATION
DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF CARDIOTHORACIC SURGERY

NAME OF APPLICANT _____ **DATE** _____

☐ Initial Appointment and/or Additional Privileges ☐ Reappointment

Applicant: Check off only those privileges expected to be performed at the site where you will be working. Note that privileges granted may only be exercised at the site(s) and setting(s) recommended by the Department Chair/Chief/Designee. Shaded areas indicate that the privilege is not applicable for that particular entity.

Department Chair/Chief/Designee: Initial the Recommended column for approved privileges. If applicable, check off the "Not Recommended" boxes. Documentation of all privileges must be provided for all privileges on the last page of this form.

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				Qualifications: For usual and customary privileges board certification by the American board of Surgery or equivalent, experience and demonstrated competence. **All physicians who apply for Cardiothoracic Surgery need to have performed a minimum of 50 cases in the past year.**			
				Core Privileges in Cardiothoracic Surgery: includes performing a history and physical, interpreting laboratory studies, interpreting and performing diagnostic studies and treatment plans for the following ages:			
				Neonates and Infants from 0 to 2 years of age			
				Children from 3 to 13 years of age			
				Adolescents and Young Adults 14 years of age and older			
				HEART AND PERICARDIUM			
				- Incision			
				• Cardiotomy, exploratory (includes removal of foreign body) with or without cardiopulmonary bypass, suture of heart wound or injury			
				• Pericardiotomy with exploration, drainage or removal of foreign body			

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REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				• Pericardiocentesis			
				• Blalock -Hanlon procedure			
				• Creation of atrial septal defect on cardiopulmonary bypass			
				• Rashkind procedure			
				- Excision			
				• Cardiectomy (for transplantation)			
				• Excision of cardiac or intracardiac tumor			
				• Pericardiectomy			
				• Ventricular aneurysmectomy			
				• Post-infarction ventricular septal defect			
				• Epicardial			
				• Pacemaker generator replacement			
				- Valvular Surgery			
				• Repair (with or without cardiopulmonary bypass)			
				• Replacement			
				-Coronary Artery Surgery			

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REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				• Aortocoronary bypass graft (includes internal mammary artery, synthetic or xenograft materials, endarterectomy, patch angioplasty, etc.)			
				• Ventricular aneurysmectomy			
				• Post-infarction ventricular septal defect			
				- Congenital Heart Disease			
				• Patent ductus arteriosus			
				• Coarctation of aorta			
				• Atrial septal defect			
				• Ventricular septal defect			
				• Endocardial cushion anomaly (complete and incomplete)			
				• Anomalous coronary vessels			
				• Anomalous pulmonary venous return			
				• Sinus of Valsalva fistula and/or aneurysm			
				• Tetralogy of Fallot (palliation or correction)			
				• Transposition of great arteries (palliation or correction)			
				• Truncus arteriosus (palliation or correction)			
				• Ebstein's anomaly			

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				• Double outlet right or left ventricle			
				• Apico-aortic conduit construction			
				• Aortic septal defect			
				• Tricuspid artesia (palliation or correction)			
				• Anomalies of the aortic arch			
				• Cortriatriatum			
				• Pulmonic stenosis or atresia (palliation or correction)			
				• Pulmonary venous obstruction			
				• Intra aortic Balloon Pump			
				• Implantation of LV assist devices			
				- **Arterial**			
				• Embolectomy, direct anywhere			
				• Embolectomy, catheter anywhere			
				• Excision and graft or direct repair for aneurysm or occlusive disease anywhere except coronary (may include excision of affected organ)			
				• Thromboendarterectomy, with or without angioplasty anywhere except coronary			
				• Bypass graft anywhere (vein, synthetic, reconstituted or viable arterial, sparks) except coronary			

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				• Exploration (not followed by surgical repair)			
				• Exploration for P.O. hemorrhage or thrombosis			
				- Trauma			
				• Arteriorrhaphy			
				• Phleborrhaphy			
				• Ligation			
				• Fasciotomy			
				- Rib Resection			
				• Cervical or first rib for thoracic outlet decompression			
				OTHERS: (Please specify) _____ _____			
				MODERATE/DEEP SEDATION PRIVILEGES			
				DECLARATION OF BRAIN DEATH PRIVILEGES			
				TEACHING ONLY			

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PRIVILEGES NOT INCLUDED ON THIS FORM: A request to perform any procedure or treatment not included on this form must be submitted to the Attending Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.

TEMPORARY CLINICAL PRIVILEGES: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted as per the LAC+USC Attending Staff Association Bylaws.

ACKNOWLEDGMENT OF PRACTITIONER:

I hereby certify that I have no physical or mental impairment which would interfere with my practice, and I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise in each group of procedures requested. I understand that in making this request I am bound by the LAC+USC Bylaws and/or policies of the hospital and medical staff.

_____ _____

APPLICANT'S SIGNATURE DATE

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Department Chair/Chief/Designee:

If there are any recommendations of privileges that need to be modified or have conditions added, indicate here:

Privilege#:_____
Condition/Modification/Explanation:_____
_____

If privileges are NOT recommended based on COMPETENCY, provide explanation:

Privilege#:_____
Explanation for NOT recommending based on
COMPETENCY:_____
_____

If supplemental documentation provided, check here: ☐

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

_____ _____

SIGNATURE OF THE DEPARTMENT CHAIR/CHIEF/DESIGNEE ***DATE***

APPROVED BY CREDENTIALS & PRIVILEGES COMMITTEE ON:	APPROVED BY EXECUTIVE COMMITTEE ON:

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APPROVED BY GOVERNING BODY ON:	PERIOD ENDING:

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