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

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
				Core Privileges in Neurosurgery: 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 Adults 14 years of age and older			
				1. Craniectomy for tumor, trauma, vascular, infectious, congenital, or degenerative intracranial for extracranial disease			
				2. Craniotomy for tumor, trauma, vascular, infectious, congenital or degenerative intracranial or extracranial disease			
				3. Chordotomy, rhizotomy			
				4. Laminectomy for tumor, trauma, vascular, infectious, congenital or degenerative disease of the spine, spinal cord or nerve roots			
				5. **Anterior decompression and/or fusion of the spine**			

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REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				• Cervical			
				• Thoracic			
				• Lumbo/Sacral			
				6. **Posterior fusion (instrumentation and/or bone) of the spine:**			
				• Cervical			
				• Thoracic			
				• Lumbo/Sacral			
				7. **Peripheral Nerve Surgery:**			
				• Nerve suture/repair			
				• Nerve entrapment release			
				• Neurolysis			
				• Nerve Graft			
				• *** Implantation of Vagal Nerve Stimulator			
				8. **Extracranial Vascular Surgery:**			
				• Carotid Endarterectomy			
				• Carotid Ligation			
				• Vertebral Endarterectomy			

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M	E	H	R			Competency	Other
				• Vertebral Ligation			
				• Carotid-vertebral anastamosis			
				9. CSF Shunt			
				10. Trans-sphenoidal Craniotomy			
				11. Tracheotomy			
				12. Ventriculostomy			
				13. Insertion of tongs for spina stabilization			
				14. Application of Halo device			
				15. Cervical and Lumbar puncture			
				16. **Insertion of dorsal column stimulator:**			
				• Open laminectomy			
				• Percutaneously			
				17. Myeloscopy			
				18. Stereotaxic craniotomy			
				19. Stereotaxic Radiosurgery			
				20. **Percutaneous exploration of the spine: (including fusion):**			
				• Thoracoscopic			

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M	E	H	R			Competency	Other
				• Laporascopic			
				21. Ventriculoscopy			
				22. *Image Guided craniotomy			
				23. *Image guided laminectomy			
				24. *Intraoperative Ultrasound			
				25. *Intraoperative Fluoroscopy			
				26. Neurosurgical Intensive Care Unit			
				27. **Use of Fluoroscopy			
				28. MODERATE/DEEP SEDATION PRIVILEGES			
				29. DECLARATION OF BRAIN DEATH PRIVILEGES			

*Special license required X-Ray Technical Supervisor License
** Requires X-Ray Fluoroscopy Certificate
*** Level II requires Additional Documentation of training and experience

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M	E	H	R			Competency	Other

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:
APPROVED BY GOVERNING BODY ON:	PERIOD ENDING:

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