Providence Hospital
of North Houston

Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_____ _____
Print Name Date

Privilege Request Form - Vascular Surgery

SECTION I – GENERAL REQUIREMENTS VASCULAR SURGERY

Requested Staff Category

_____ Active _____ Courtesy _____ Consulting _____ Affiliate

Basic Education: MD or DO

INITIAL APPOINTMENT

Minimal formal training and experience:

- Successful completion of an ACGME–accredited vascular residency or fellowship training program or an AOA-approved training program in vascular surgery.
- The number of cases performed in the last 12 months for each procedure requested along with the documentation of proficiency must be sufficient to validate competence. An applicant who has just completed a residency shall provide his/her residency log. Additional documentation and monitoring may be required at the discretion of the Medical Director or the Chief of Staff. Some procedures may require additional documentation of training and experience which is acceptable to the Medical Director such as Proctoring Reports, Operative Reports and Discharge Summaries for other institutions, written communication of documents from the Chairperson of the designee of an approved academic training program, approved continuing medical education course, or clinical department from another institution attesting to completion of a specified course of training, and/or the number of the specified successful procedures performed, and/or the applicants known ability to perform a specific procedure for which the applicant has previously been formally trained to carry out in an approved program.
- Member in good standing of an accredited acute care hospital and/or ambulatory surgery center, with the same or similar unrestricted privileges.
- Certification by the American Board of Surgery (ABS), American Osteopathic Board of Surgery (AOBS) is preferred.
- Interview by the Medical Director and/or Chief of Staff when requested.

Providence Hospital
of North Houston

Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_____ _____
Print Name Date

REAPPOINTMENT MAINTENANCE OF PRIVILEGE

- Demonstrated evidence of clinical activity from relevant professional practice evaluation during the past 24 months without significant quality variations, OR
- Peer recommendations when performance data is insufficient at the time of reappraisal; and
- Ongoing maintenance of continuing medical education as it pertains to scope of license and specialty.

SECTION II – PRIVILEGES REQUESTED

Core Procedures	Requested	Granted	Denied
Admit Patients			
Perform H & P			
Provide consultation to determine need for surgical intervention			
Order diagnostic studies & procedures			
Order medications			
Post-surgical evaluation and treatment			
Medical management of post-surgical patients using prudent and good medical judgment for appropriate consultation			

Surgical Procedures	# Procedures in last 12 months	Requested	Granted	Granted w Conditions	Denied
Acute mesenteric ischemia, evaluation and management					
Aneurysm, evaluation and management					
Angiography of extremities and intra/extra cranial arteries					
Anti-colagulation therapy					
Atherosclerosis, evaluation and management					
Carotid artery disease, evaluation and					

Providence Hospital
of North Houston

Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_____ _____
Print Name Date

Surgical Procedures	# Procedures in last 12 months	Requested	Granted	Granted w Conditions	Denied
management					
Carotid duplex studies, interpretation					
Cerebravascular occlusive disease, evaluation and management					
Chronic mesenteric ischemia, evaluation and management					
Deep vein thrombosis, evaluation and management					
Lower extremity venous ultrasound, interpretation					
Non-invasive pulse volume recordings, interpretation					
Percutaneous placement of central lines (i.e., dialysis catheter)					
Peripheral arterial duplex studies, interpretation of					
Peripheral arterial physiologic studies, interpretation					
Thoracic outlet syndrome, evaluation and management					
Transcranial Doppler studies, interpretation					
Varicose veins treatment					
Vena cava filter, placement					
Venous disease, evaluation and management					
Venous duplex studies, interpretation					
Venous occlusive disease treatment					
Venous reflux evaluation					
Visceral duplex studies, interpretation					

I have been approved for these procedures at the following hospitals/ambulatory surgery centers:

Providence Hospital
of North Houston

Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_____ _____
Print Name Date

SECTION III - ACKNOWLEDGE OF PRACTITIONER:

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at the Hospital. I hereby attest that the references, reports, records and information are available that verify my qualifications and competency to practice as requested.

I understand that:

1. In exercising any clinical privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

2. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.

3. The use of any other new, untried, or unproven procedure/treatment modality/instrumentation maybe performed or used, only after the regular credentialing process has been completed and the privilege to perform or use said procedure/treatment modality/instrumentation has been granted to the individual practitioner

_____ _____
PHYSICIAN SIGNATURE **DATE**

Providence Hospital
of North Houston

Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_____ _____
Print Name Date

SECTION IV – RECOMMENDATIONS AND APPROVALS

Recommendation of the Medical Director:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

_____ Approval of all requested privileges

_____ Approval of the following privileges with conditions:
_____

_____ Denial of the following privileges:
_____

_____ _____
Medical Director **Date**

Recommendation of the Medical Executive Committee:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

_____ Approval of all requested privileges

_____ Approval of the following privileges with conditions:
_____

_____ Denial of the following privileges:
_____

_____ _____
Chief of Staff **Date**

Providence Hospital
of North Houston

Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_____ _____
Print Name Date

Decision of the Governing Board:

The Governing Board has reviewed the above recommendations regarding the requested clinical privileges and supporting documentation for the above named applicant and has:

_____ Granted all requested privileges

_____ Granted the following privileges with conditions:
_____

_____ Denied the following privileges:
_____

_____ _____
Chairman of the Board **Date**