Applicant
Name:_____

REQUEST FOR SURGICAL PRIVILEGES

I hereby request privileges, as a Interventional Radiologist. The procedures I wish to do in your facility are listed below.

I understand that privileges granted are subject to a bi-annual review coinciding with reapplication for medical staff membership. I also understand that application for additional or new procedures can be made at any time with proper documentation. The following privileges are requested and are consistent with my abilities, training, and experience.

Documentation of training and experience is attached for all procedures requested as in the form of approved delineated privileges approved by either the acute care hospital or the outpatient ambulatory surgery center setting. Having the experience from one of these institutions can be used as the proof of my experience coupled by college, residency, and fellowships herein.

APPLIED FOR	APPROVAL	
The applicant must check the boxes to the left, the right side boxes are used for formal approvals of the governing body.	❑ YES	❑ NO
❑ Arterial	❑ YES	❑ NO
❑ Venous	❑ YES	❑ NO
❑ Visceral	❑ YES	❑ NO
❑ Spine	❑ YES	❑ NO
❑ Kyphoplasty	❑ YES	❑ NO
❑ Kidney biopsy	❑ YES	❑ NO
❑ Liver biopsy	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑ History and Physical	❑ YES	❑ NO
❑ Conscious Sedation	❑ YES	❑ NO
❑ Local Anesthesia	❑ YES	❑ NO
❑ Supervision of a conscious sedation RN or other Advance Allied Professional	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

APPLIED FOR	APPROVAL	
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

Applicant Print Name

Signature of Applicant

Date

Signature of QI Committee Chairperson

Date

Signature of Governing Body Chairperson

Date