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)

(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)

(Additional procedures require consideration/approval of the Department.)
Cardiovascular Thoracic Section
Privilege Request Form

Applicant's Name: ____________________________________________________________________ (Please Print)

### CATEGORY III. MAJOR COMPLEXITY

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

#### A. CARDIAC SURGERY
- Transthoracic placement of pacemaker
- Pericardieectomy
- Repair of Congenital anomalies
  - with cardiopulmonary bypass
  - without cardiopulmonary bypass
- Valve repair or replacement
- Ascending aortic aneurysm
- Dissecting aneurysm

- *Other: (specify)

#### B. THORACIC SURGERY
- Repair of chest wall deformity
- Exploratory thoracotomy
- Thoracotomy for hemorrhage
- Pulmonary resection
- Decortication
- Thoracotomy for mediastinal tumor
- Thoracoplasty

- *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

- *Other: (specify)

*Additional procedures require consideration/approval of the Department.*
Cardiovascular Thoracic Section
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Applicant's Name: ________________________________
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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)

********************************************************************************
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
(if requesting interim privileges)  Date

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:

<table>
<thead>
<tr>
<th>CO₂ Laser</th>
<th>ND: YAG Laser</th>
<th>ND: YAG Ophthalmic Laser</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Endoscopy</td>
<td>___ Endoscopy</td>
<td>___ Q Switched</td>
</tr>
<tr>
<td>___ Laparoscopy</td>
<td>___ Laparoscopy</td>
<td>___ Contact</td>
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<tr>
<td>___ Open surgical</td>
<td>___ Open surgical</td>
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<tr>
<td>___ Arthroscopy</td>
<td>___ Arthroscopy</td>
<td>___ Holmium YAG Laser</td>
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<td></td>
<td>___ Intravascular</td>
<td></td>
</tr>
</tbody>
</table>

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: __________________