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Applicant Name

**St. Elizabeth Healthcare**  
**Cardiovascular Surgery**

**Minimum Requirements**

Degree required: MD or DO

Successful completion of ACGME or AOA approved residency training program in cardiovascular surgery

**Note:** Members who first apply for membership after March 2, 2009 must be and remain (with a lapse of no longer than one year) board certified in cardiovascular surgery, or become and remain (with a lapse of no longer than one year) board certified within six years of completion of their post-graduate medical training. Only those boards recognized by the American Board of Medical Specialties or the American Osteopathic Association are acceptable. This board certification requirement does not apply to applicants who on March 2, 2009 were members in good standing on the medical staff of the St. Luke Hospitals or St. Elizabeth Medical Center.

**Privileges Requested**

**I. Core Privileges:** Core privileges in cardiovascular surgery include the care, treatment or services listed immediately below. I specifically acknowledge that board certification alone does not necessarily qualify me to perform all core privileges or assure competence in all clinical areas. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below. Please line through and initial any specific privileges within a checked privilege group that you are not requesting.

<b><u>Request</u></b>	<b><u>Description of Privilege</u></b>
_____	Admit patients and perform histories and physicals
_____	Moderate Sedation (requires proof of (a) board certification in Anesthesiology, Cardiology, Intensive Care, Pulmonology or Emergency Medicine <i>or</i> (b) current ACLS Certification <i>or</i> (c) satisfactory completion of the ASA Moderate Sedation course).
_____	Carotid endarterectomy
_____	Coronary artery bypass grafting
_____	Heart valve repair or replacement

- \_\_\_\_\_ Placement of permanent pacemaker/implanted automatic defibrillator
- \_\_\_\_\_ Placement of pulmonary artery monitoring catheters
- \_\_\_\_\_ Repair of acquired defects of the heart
- \_\_\_\_\_ Repair of congenital heart defects in an adult
- \_\_\_\_\_ Repair of femoral artery/vein
- \_\_\_\_\_ Repair or replacement of the great vessels.
- \_\_\_\_\_ Use of cardiopulmonary bypass
- \_\_\_\_\_ Use of intra-aortic balloon pump
- \_\_\_\_\_ Use of ventricular assist device

**II. Additional Privileges:** In addition to the core privileges requested above, I am requesting the additional privileges below. In addition to meeting the minimum requirements for core privileges, applicants must meet all “Additional Requirements” listed for each privilege below and provide documentation (fellowship completion, training course certification, letter from program director or department chair at primary hospital, etc.) demonstrating appropriate education, training, ability and current competence. Credentialing bodies or persons may request additional documentation or information. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below.

<u>Request</u>	<u>Description of Privilege</u>	<u>Additional Requirements</u>
_____	Atrial Fibrillation Procedure	Recognized training program
_____	Transmyocardial Revascularization	Recognized training program
_____	Thoracic Endoaortic Graft Placement	Recognized training program

_____	Implantation of Bi-Ventricular pacemaker	Recognized training program
_____	Flouroscopy	Radiation safety test or documented training

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Printed Name

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\_\_\_\_\_ Approved

\_\_\_\_\_ Disapproved

\_\_\_\_\_  
Chair, Section of \_\_\_\_\_

Date:

Remarks: