

PEDIATRIC CARDIOTHORACIC SURGERY PRIVILEGE FORM

NAME: _____ EFFECTIVE DATE: _____ To _____

LEGEND: 1 - Baptist 2 - Beaches 3 - Nassau 4 - St. Luke's 5 - St. Vincent's
6 - Shands Jax/SJ TCU 7 - Wolfson 8 - Brooks 9 - South

The minimum education, training and experience qualifications for core privileges are as delineated in each hospital's Medical Staff Bylaws, Rules and Regulations, or policies. Please consult these documents to determine your eligibility to request these privileges.

To request Core Privileges, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	10	11	12	CORE PRIVILEGES	APPR
												Admission, assessment and performance of surgical care to correct or treat various conditions of the chest wall, mediastinum, lungs, great vessels, heart, related blood vessels and pulmonary system in infants and children. These privileges do not include any of the Special Procedures listed separately	

To request Special Procedures, please place an "X" in the appropriate hospital column. If the condition/privilege you desire is not included on this form, please submit a separate written request along with appropriate documentation of training and/or experience.

1	2	3	4	5	6	7	8	9	10	11	12	SPECIAL PROCEDURES	APPR
												Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training or experience.	
												Congenital Open Heart Surgery [Hospital 7 ⁺⁺]	
												Deep Sedation [Hospital 7 ⁺⁺]	
												Extra Corporeal Membrane Oxygenation (ECMO) Cannula Insertion & Removal [Hospital 7 ⁺⁺]	
												Inferior Vena Cava ("IVC") Filter Placement [Hospital 7 ⁺⁺]	
												Moderate Sedation/Analgesia [Hospital 7 ⁺⁺]	
												Surgical Ablation of Aberrant Conduction Pathways	
												Thoracoscopic Surgery [Hospital 7 ⁺⁺]	
												Ventricular Assist Device (Tandem Heart) [Hospital 7 ⁺⁺]	
												If the condition/privilege you desire is not included on this form, please submit a separate written request for the privilege along with documentation of training and/or experience.	

Acknowledgement of Practitioner: I understand that (a) in exercising clinical privileges granted, I am constrained by each hospital's Medical Staff Policies, rules and regulations, and (b) 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 each hospital's Medical Staff Bylaws.

Applicant Signature: _____ Date: _____

- If blacked out, this privilege is not available in this specialty at this hospital.
- ++ Please refer to this hospital's Bylaws or Rules and Regulations regarding specific criteria to be met before this privilege may be granted.