MEDSTAR UNION MEMORIAL HOSPITAL
DELINEATION OF PRIVILEGES
ANESTHESIOLOGY

Print Form

Name (print or type): _____
Last First M.I.

| CORE PRIVILEGES: | REQUESTED | RECOMMENDED | COMMENTS |
|---|---|---|---|
| Consulting privileges for diagnoses generally regarded as part of the specialty of Anesthesiology<br><br>General Anesthesia (Not Open Heart)<br>Deep Sedation<br>Regional Anesthesia<br>Spinal<br>Epidural<br>Caudal<br>I.V. Regional Anesthesia<br>Peripheral Nerve Blocks with/without continuous catheter placement<br>Acute Pain Management<br>Cardiac and Respiratory Resuscitation<br>Application of Specific Methods of Inhalation therapy<br>Oral/Nasal Intubation<br>Supraglottic airway placement and management<br>Management of Fluid, Electrolyte, and Metabolic Disturbances<br>Peripheral Vascular Cannulation<br>Central Vein/Pulmonary Artery Catheter placement and monitoring<br>Perioperative Fiberoptic Bronchoscopy<br>Placement/management of external/internal pacemaker | | | |
| | | | |
| NON CORE PRIVILEGES: | | | |
| Open Heart General Anesthesia | | | |
| Intraoperative Transesophageal Echocardiography | | | |
| Perioperative ultrasound for central/ peripheral line placement or during the performance of regional anesthesia | | | |
| | | | |
| OTHER: | | | |
| Evidence of completion of departmental compliance MH (malignant hyperthermia)/POC (point of care testing) glucometer or ACT. | | | |

**ACLS: Must show current certification prior to credentialing and re-credentialing**

**BOARD CERTIFICATION: All new hires must obtain certification within 4 years of completing residency. If certificate is renewable must show evidence that re-certification process is occurring.**

**EMERGENCY:**

**Emergency Privileges:** In an emergency all members in the department of anesthesia shall be authorized to treat any medical or surgical disease or condition and/or perform any medical or surgical procedures dictated by the situation. An emergency is defined as a situation in which delay in instituting treatment could result in serious harm to the patient or present an immediate threat to the life of the patient when no more qualified provider is available.

(Electronic) By typing my name below, I certify the above statements to be true and correct to the best of my knowledge, and that this information can be used for the purpose of processing my MedStar Union Memorial Hospital Delineation of Privilege Form. (Non-Electronic) If filling out the delineation by hand, please provide your original signature and date.

_____
Applicant's Signature Date

Reviewer's Comments:

I certify that I have reviewed the applicant's application for initial appointment or reappointment and request for delineation of privileges, and that I recommend the approval of the delineations of privileges as specified above.

_____
Department Chief Signature Date