DELINEATION OF PRIVILEGES
PRACTICE AREA: **VASCULAR SURGERY**

To request these clinical privileges, the following threshold criteria must be met:

1. Licensed by the State of Iowa as M.D. or D.O., **AND**

2a. Board Certification by the American Board of Surgery in Vascular Surgery or the American Osteopathic Board of Surgery in General Vascular Surgery, **OR**

2b. Successful completion of an ACGME or AOA accredited residency program in vascular surgery **WITH** board certification in 5 years or less of residency completion. **AND**

3. Maintain admitting vascular surgery privileges at one of the UnityPoint Health-Des Moines Hospitals, of the Mercy Health Network-Des Moines Hospitals, VA Central Iowa Health Care System or Broadlawns Medical Center. Surgeons with VA privileges only will be limited to schedule adult patients only at the center.

VASCULAR SURGERY PRIVILEGES - **I am requesting vascular surgery privileges for:**

Requested	Granted	
□	□	Correct / treat conditions, diseases, disorders, & injuries of the peripheral vascular system
□	□	Excision / Repair / Removal / Biopsy of vascular lesions
□	□	Peripheral Vein ligation / stripping / removal / revision
□	□	Vascular access procedures
□	□	Operation, interpretation and reporting of X-ray and C-arm imaging
□	□	Administration of local anesthesia
□	□	Administration of minimal sedation
□	□	Administration of moderate sedation-**Requires Request of Moderate Sedation Form**
□	□	Admission to overnight care services
□	□	Supervision of Allied Health Practitioner/Residents/Students

To admit patients, perform histories and physicals, order diagnostic tests, request consultations, provide consultations within the scope of your privileges, use all skills normally learned during medical school and residency and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the facility.

You are expected to practice within the bounds of your training and competence and should not attempt to treat cases, which are not in your scope of practice. Newly developed treatment modalities are not included in this request and must be cleared by the Medical Executive Committee and Governing Board before their performance. Please become familiar with the capabilities and limitations of this facility.

I understand that in making this request I am bound by the applicable bylaws and/or policies of Lakeview Surgery Center and hereby stipulate that I meet the threshold criteria for this request. I also certify that I have knowledge to operate all the equipment necessary to carry out requested procedures.

_____ _____
Date Applicant's Signature

_____
Applicant's Name Printed

Privileges:
Granted _____ Deferred _____ _____
MEC Signature **Date**

Granted _____ Deferred _____ _____
GB Signature **Date**

Modifications**:**

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