

Privileges in Neurosurgery Service

Name: _____
Please Print Name

MEDICAL STAFF CATEGORY REQUESTED:

- Active** – Uses Stanford Hospital & Clinics (SHC) as a primary hospital and regularly admits/treats, consults, patients at this facility, or is regularly involved in medical staff functions (minimum 11 pt contacts per year)
- Courtesy-Teaching** – Treats SHC patients only when incident to performing clinical teaching responsibilities must have a teaching appointment with the Stanford School of Medicine.

ONLY provide care of patients in the SHC Emergency Department, ASC, Cath Lab, Cancer Center or Endo Unit – requires Active or Courtesy Status at LPCH

Please indicate any teaching title you may hold with the Stanford School of Medicine:

- Faculty (MCL or UTL) Clinical Educator Adjunct Clinical Faculty

Teaching Title: _____

REQUESTED	PROCEDURE	INITIAL CRITERIA	RENEWAL CRITERIA	PROCTORING REQUIREMENTS
CORE PRIVILEGES				
<input type="checkbox"/>	<p><u>Neurosurgery Core:</u> Privileges to admit, evaluate, diagnose, consult, perform history and physical exam, and provide pre-, intra-, and postoperative neurosurgical treatment to patients presenting with illnesses, injuries, and disorders of the central and peripheral nervous system, including their supporting structures and vascular supply; provide consultation; and order diagnostic studies and procedures related to the neurological problem.</p> <p><u>Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges</u></p> <p>Core privileges could include, but not limited to:</p> <ul style="list-style-type: none"> • Peripheral nerve surgery • Spine and spinal cord procedures • Cranial surgery • Treatment of simple concussion or severe back or neck pain due to disc disease, nerve entrapment syndrome; herniated discs; hydrocephalus; ruptured intracranial aneurysm or arteriovenous malformation • Frameless stereotactic surgery • Tracheostomy 	<p>Successful completion of an ACGME or AOA accredited residency or fellowship in Neurosurgery or foreign equivalent training.</p> <p style="text-align: center;"><u>AND</u></p> <p>Current certification or active participation in the examination process leading to certification in Neurosurgery by the American Board of Neurological Surgery or the American Osteopathic Board of Neurological Surgery or equivalent documentation or foreign equivalent training/board.</p> <p style="text-align: center;"><u>AND</u></p> <p>Documentation or attestation of the performance of at least 100 Neurosurgical procedures as an attending physician or as a senior resident in the last 2 years.</p>	<p>Appropriate number of cases performed per year as based on Category</p> <p>_____ # of cases in 2 years</p> <p>Minimum 20 cases required, may include those cases done at other facilities</p>	<p>2 chart reviews</p>

SPECIAL PRIVILEGES				
(MUST ALSO MEET THE CRITERIA ABOVE)				
Requested	PROCEDURE	ADDITIONAL CREDENTIALING CRITERIA	# of Cases performed in past 2 yrs **	PROCOTORING REQUIREMENTS
<input type="checkbox"/>	Provide care of patients in the SHC Emergency Department, ASC, Cath Lab or Endo Unit ONLY	Must have Active or Courtesy status at LPCH	Maintenance of initial criteria	
<input type="checkbox"/>	Administration of Moderate Sedation	In accordance with Hospital Sedation Policy and completion of the SHC sedation exam	Sedation exam every 4 years	
<input type="checkbox"/>	Treatment of patients in outpatient clinics at Stanford Hospital & Clinics	Must have teaching appointment through the Stanford School of Medicine.		
<input type="checkbox"/>	Use of fluoroscopy equipment (or supervision of other staff using the equipment)	'Radiology Supervisor and Operator Certificate' or 'Fluoroscopy Supervisor and Operator Permit' required	Maintenance of valid Fluoroscopy or Radiology Certificate	
<input type="checkbox"/>	Admit, treat, perform surgical procedures, or provide follow-up care for inpatients ages 14 years or younger	Must have membership and privileges at Lucile Packard Children's Hospital	_____ # of cases in 2 years	
<input type="checkbox"/>	Lumbar fusion	Required minimum of 10 cases	_____ # of cases in 2 years Minimum 5 cases required	2 chart reviews
<input type="checkbox"/>	Thromboendarterectomy of carotid or vertebral circulation	Required minimum of 10 cases	_____ # of cases in 2 years Minimum 5 cases required	2 chart reviews
<input type="checkbox"/>	Sympathectomy	Required minimum of 10 cases	_____ # of cases in 2 years Minimum 5 cases required	2 chart reviews
<input type="checkbox"/>	Surgery for vascular malformation of the spinal cord or spinal canal	Required minimum of 10 cases	_____ # of cases in 2 years Minimum 5 cases required	2 chart reviews
<input type="checkbox"/>	Percutaneous stimulation of the spinal cord	Required minimum of 10 cases	_____ # of cases in 2 years Minimum 5 cases required	2 chart reviews
<input type="checkbox"/>	Spinal surgery involving the use of various stabilization devices	Required minimum of 10 cases	_____ # of cases in 2 years Minimum 5 cases required	2 chart reviews
<input type="checkbox"/>	Stereotactic Radiosurgery Performed in collaboration with Radiation Oncology	<ul style="list-style-type: none"> • Acuray training course • Observe ten (10) cases • Proctored for ten (10) cases • Stanford XRT letter of approval • Letter from co-director of cyberknife procedure 	_____ # of cases in 2 years Minimum 5 cases required	2 chart reviews

<input type="checkbox"/>	Vertebroplasty	Required minimum of 10 cases	_____# of cases in 2 years Minimum 5 cases required	2 chart reviews
<input type="checkbox"/>	Radiosurgery Treatment for Functional Applications ***Panel review report of outcomes required	Primary specialty training in neurosurgery Board Certified by American Board of Neurological Surgery 2 years experience in Functional Neurosurgery and privileges in Stereotactic Radiosurgery; or 200 cases of Stereotactic Radiosurgery	_____# of cases in past 2 years Minimum 3 cases required	2 observations or 2 chart reviews

**** On a separate sheet of paper, please describe any major, unexpected complications you have encountered for any of the Core Privileges or Additional Privileges you are requesting**

NOTE: PROCTORING IS REQUIRED FOR ALL INITIAL PRIVILEGES REQUESTED and MUST BE COMPLETED WITHIN 12 MONTHS

ACKNOWLEDGMENT OF PRACTITIONER:

I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at Stanford Hospital & Clinics. I also acknowledge that my professional malpractice insurance extends to all privilege I have requested.

I understand that in exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

Applicant Signature: _____ Date _____

If sending by email, type your name in the box above.
 If sending by mail, please print first and then sign.