Huntington Hospital

Delineation Of Privileges

Electrophysiology Privileges

Provider Name:

Privilege	Requested	Tabled	Approved

ELECTROPHYSIOLOGY PRIVILEGES

Criteria:

a) Board Certification with subspecialty in Cardiovascular Disease
b) The first three (3) years appointment is conditional pending board certification in Electrophysiology
c) Conditional appointment is subject to completion of approved program in Electrophysiology

Proctoring Requirements: Proctoring requirements are outlined under each procedure below.

ELECTROPHYSIOLOGY PROCEDURES: ___ ___ ___

Includes the management and coordination of care, treatment and services, including; Medical history and physical examination, consultation and prescribing medication in accordance with DEA certificate.

INTERNAL CARDIAC DEFIBRILLATOR and BI-VENTRICULAR ICD IMPLANTATION:

Criteria: Must be board certified in Electrophysiology AND provide evidence (certificate) of completion of thirty (30) cases in an approved training program.

a) Biventricular ICD implantation ___ ___ ___
Proctoring Requirements: One case by direct observation

b) Internal cardiac defibrillator implantation ___ ___ ___
Proctoring Requirements: One case by direct observation

ELECTROPHYSIOLOGIC STUDIES OF THE HEART - ABLATION ___ ___ ___

Criteria: Must be board certified in Electrophysiology and provide evidence (certificate) of completion in an approved training program.

Competency Requirements: Applicants must provide evidence of performing the following number of procedures over a two-year period of time for the specific Supplemental Privilege requested above:

a) Five (5) EP Studies
b) Two (2) Ablations
c) Two (2) Transeptals
d) Two (2) ICD

a) Comprehensive diagnostic EP ___ ___ ___
Proctoring Requirements: One case by direct observation

b) Transcatheter ablation and mapping ___ ___ ___
Proctoring Requirements: One case by direct observation

Revised: 07/22/2010

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ACKNOWLEDGEMENT OF THE PRACTITIONER:

I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at Huntington Hospital, and I understand that: a) in exercising my clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation; b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature of Applicant: _____ Date:_____

DEPARTMENT CHAIR RECOMMENDATIONS

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Applicant may perform privileges and procedures as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

APPROVALS:

Section Chair: _____ Date: _____

Deparetment Chair: _____ Date: _____

Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____