

Loma Linda University Medical Center
Loma Linda, CA 92354
RADIOLOGY AND NEUROSURGERY SERVICE
SUPPLEMENTAL PRIVILEGE FORM

Name: _____

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	ENDOVASCULAR SURGICAL NEURORADIOLOGY
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QUALIFICATIONS

	<p>Requires:</p> <ol style="list-style-type: none"> 1. Evidence of performance and interpretation of a substantial number of previous percutaneous carotid/vertebral cerebral angiograms as primary operator (100 or more recommended); may have been performed during residency/fellowship. 2. Successful completion of interventional neuroradiology fellowship or endovascular surgical neuroradiology fellowship training, or equivalent training as approved by the LLUMC Service Chiefs of Radiology and Neurosurgery, with documentation of extensive training and performance for described and requested procedure types, as well as advanced education in brain and spinal cord anatomy and physiology. 3. Moderate Sedation Certificate (attach copy) 4. Fluoroscopy Supervisor and Operator Permit required for Neurosurgeons and not Board Certified Radiologists. (attach copy) Radiology X-ray Supervisor and Operator Certificate required for Board Certified Radiologists (attach copy). 5. Commitment to advancement of patient care goals of the Radiology and Neurosurgery Services is necessary.
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GENERAL DESCRIPTION

Includes supervision, interpretation and performance of spinal and cervicocerebral angiography and neurointerventional procedures such as vertebroplasty/kyphoplasty, head and neck vascular or tumor embolization, carotid and vertebral arterial stenting, intracranial thrombolysis and/or mechanical thrombectomy, intracranial vascular angioplasty/stenting, and use of endovascular embolization agents (e.g. coils, glue) for treatment of brain or spinal cord abnormalities.

MARK IF REQUESTED	PRIVILEGES REQUESTED	ACTION		
		Approved	Conditions	Denied
	Supervision of residents and students			
	Supervision of Allied Health Professionals under the following circumstances: AHP is granted practice privileges by the Medical Staff AHP operates under standardized procedures Other circumstances as recommended by the IDP Committee and approved by the Medical Staff			
	1. Vertebroplasty/kyphoplasty			
	2. Percutaneous cervicocerebral/spinal angiography (required as prerequisite to privileges below)			
	3. Percutaneous head and neck embolization			
	4. Percutaneous extracranial carotid/vertebral arterial stenting			
	5. Percutaneous intracranial vascular thrombolysis/mechanical embolectomy			
	6. Percutaneous intracranial and intraspinal embolization, angioplasty, vascular stenting.			

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Acknowledgment of Practitioner

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Loma Linda University Medical Center, Inc.; **and I understand that:**

- (a) In exercising any clinical privileges granted, I am constrained by any 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 situation my actions are governed by the applicable section of the Medical Staff Bylaws.

Signed: _____

Date: _____

****** For Medical Staff Use Only ******

Conditions/Modifications:

The requested clinical privileges have been approved with the following conditions/modifications and the explanation for same.

Code	Privilege	Condition/Modification

Recommended by:

Requires signatures of both Radiology and Neurosurgery Service Chiefs.

Radiology Service Chief

Date

Neurosurgery Service Chief

Date

Credentials Committee

Date

Medical Staff Executive Committee

Date

Approved by:

Governing Board Officer

Date