# *Regions Hospital*
# *Delineation of Privileges*
# *Perfusionist*

**Applicant's Name:**_____ _____

**Last First M Date**

**Instructions: Applicants must provide complete names and addresses for their references. <u>Please DO NOT SEND letters of recommendation along with your application</u>. These must be primary source verified by Regions Hospital. If documentation of cases or procedures is required, please attach case and/or procedural logs to your privilege delineation.**

## ☐ CORE I- General Privileges Perfusionist

| Privileges | Basic Education & Minimal Formal Training | Required Documentation and Experience |
|---|---|---|
| Perfusionist privileges include the following: assemble, operate and maintain pump oxygenator equipment; calculate and determine patient data relating to blood flow rates, ventilating gas flow rates, and medication doses; interpret laboratory values and assess adequacy of perfusion administer solutions, medications, and blood products as needed and so directed by a physician remain appraised of and assess new technical protocols and new cardiopulmonary bypass equipment, ventricular assist devices myocardial protection techniques. | 1. A.A., B.A. or B.S.<br>2. The application must demonstrate successful completion of an accredited cardiovascular perfusion education program **AND** current certification --or active participation in the examination process -- by the American Board of Cardiovascular Perfusion. | <u>New Applicants:</u><br><br>1. **Name and addresses of** clinical competency committee chair **<u>OR</u>** program director of an accredited school of perfusion **<u>OR</u>** from a supervising cardiac surgeon.<br>_____<br>_____<br>_____<br><br><u>Reappointment Applicants:</u><br><br>1. **Evaluation of your competency conducted by a peer (Perfusionist of your choice)**. Please indicate name and address of the individual whom we may contact.<br>_____<br>_____<br>_____ |

**TO BE COMPLETED BY APPLICANT:**

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges <u>will not proceed</u> until which time that the information is received.

_____ _____

Signature Date

**TO BE COMPLETED BY SPONSORING PHYSICIAN:**

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

_____ _____

Sponsoring Physician's Signature Date

**TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL:**

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

_____ _____

Regions Division/Section Head Signature Date