UNIVERSITY OF MARYLAND MEDICAL CENTER
Department of Anesthesiology
Delineation of Privilege Form

Name: _____ **Date:** _____

Board Certification Status: **American Board of Anesthesiology** _____ **Yes** **Year:** _____
_____ **Eligible until:** _____
_____ **No**

Other Boards: _____ _____ **Yes** **Year:** _____
_____ **Eligible until:** _____
_____ **No**

Privilege/Operative Procedure	**Check (√) if Requested**	**Chair Approval** Initial if Yes Write Not Approved if No
Category 0: In the case of an emergency, any member of the Medical Staff, to the degree permitted by his/her license and regardless of Medical Staff status, service or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. ***Approved per the Medical Staff Bylaws***	√*	**Yes**
Category I - Core Privileges: To be eligible for core privileges, applicants must have completed an ACGME approved Anesthesiology residency program *and be Board Certified or Equivalent.*		
Category II: to be eligible for Category II privileges, applicants must have completed an ACGME approved Anesthesiology residency program, *be Board Certified or Equivalent*, and provide documentation as to course work and recent experience. Category II privileges are as follows:		
A. Acupuncture		
B. Hypnosis		
C. Hyperbaric Medicine		
D. Neurophysiologic Monitoring/Interpretation		
E. Echocardiography (Acquisition/Interpretation)		
1. TTE		
2. TEE		
F. Special Techniques		
1. Hypothermia		
2. Deliberate Hypotension		
3. Cardiopulmonary Bypass Management ***Not to be requested by STC faculty**		
4. Temporary Pacemaker Insertion		
5. Chest Tube Thoracostomy		
6. Rapid Infusion System		
Category III: to be eligible for Category III privileges, applicants must have completed an ACGME approved Anesthesiology residency program, *be Board Certified or Equivalent, and completion of the appropriate fellowship or equivalent.* Category III privileges are as follows:		
A. Transplant		
1. Heart		
2. Lung		
3. Liver		
B. IABP Placement/Management		
C. Critical Care Unit Director/Co-Director/Attending		
1. Adult		
2. Pediatric		
D. Pediatric Cardiovascular		

Name: _____ **Date:** _____

Privilege/Operative Procedure	**Check (√) if Requested**	**Chair Approval** **Initial if Yes** **Write Not Approved if No**
E. Pediatric Transplant (heart, lung, liver)		
F. Neonatal Anesthesia (0-1 month)		
G. Pain Procedures requiring radiologic guidance and/or OR resources		
H. Epiduroscopy		
Category IV: Special/Cross Disciplinary Procedures:		

_____ _____
Applicant's Signature Date

_____ _____
Yvette Fouche, MD, Division Chief STC, Anesthesiology Date
(required for STC faculty only)

_____ _____
Peter Rock, MD, MBA, Chairman of Anesthesiology Date

(Required if any privilege requested is not approved)

_____ _____
Applicant's Confirming Signature Date