

# *Regions Hospital Delineation of Privileges Perfusionist*

Applicant's Name: \_\_\_\_\_  
Last
First
M
Date

**Instructions:** Applicants must provide complete names and addresses for their references. Please DO NOT SEND letters of recommendation along with your application. 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.	<ol style="list-style-type: none"> <li>1. A.A., B.A. or B.S.</li> <li>2. The application must demonstrate successful completion of an accredited cardiovascular perfusion education program <b>AND</b> be certified by the American Board of Cardiovascular Perfusion.</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. <b>Name and addresses of</b> clinical competency committee chair <b>OR</b> program director of an accredited school of perfusion <b>OR</b> from a supervising cardiac surgeon.</li> </ol> <p>_____</p> <p>_____</p> <p>_____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> <li>1. <b>Evaluation of your competency conducted by a peer (Perfusionist of your choice).</b> Please indicate name and address of the individual whom we may contact.</li> </ol> <p>_____</p> <p>_____</p> <p>_____</p>

**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 will not proceed 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