

**Harris Methodist Southlake
Center for Diagnostics and Surgery**

Privileges in Moderate Sedation

Name: _____

Please indicate with a check mark the privileges requested.

Qualifications

To be eligible for privileges in Moderate Sedation, the applicant must meet the following qualifications:

- Documentation of the performance of at least 10 moderate sedation procedures performed within the last year including results/outcomes and appropriate care for complications, if any **AND** documentation of current ACLS certification. For reappointment: documentation of 20 cases with results/outcomes and appropriate care for complications, if any **AND** documentation of current ACLS certification
- and**
- Current ABMS certification or eligibility to participate in the examination process leading to certification;
- and**
- Successful completion of a postgraduate residency accredited by the ACGME, AOA, or oral surgery.

_____ **Privileges in moderate sedation**

Promoting a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Acknowledgement of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at **Harris Methodist Southlake**, and

I understand that:

- (a) In exercising any 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.

Signed: _____

Date: _____

Credential Committee recommendations: _____ **Recommend** _____ **Deny**

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

Signed: _____

Date: _____

Recommended/Not recommended with the following modification(s) and reason(s):

