Union West Surgery Center
PRIVILEGE REQUEST: ANESTHESIA

Provider Printed Name:_____
Provider Signature:_____
Date:_____

PROCEDURE	REQUESTED	APPROVED
ARTERIAL PUNCTURE		
BRACHIAL PLEXUS ANESTHESIA		
CAUDAL ANESTHESIA		
EMERGENCY TREATMENT		
EMERGENCY/THERAPEUTIC LARYNGOSCOPY AND/OR BRONCHOSCOPY		
ENDOTRACHEAL INTUBATION		
EPIDURAL ANESTHESIA		
GENERAL ANESTHESIA		
INHALATION ANESTHESIA		
INTRATHECAL/EPIDURAL NARCOTICS		
INTRAVENOUS ANESTHESIA		
LOCAL ANESTHESIA		
MONITORED ANESTHESIA CARE		
PRE AND POSTOP CONSULTATION AND EVALUATION		
REGIONAL ANESTHESIA		
RESUSCITATION		
SPINAL ANESTHESIA		
SUPERVISION OF NON-PHYSICIAN PERSONNEL		
TOPICAL ANESTHESIA		
TRACHEOTOMY		
VENTILATOR MANAGEMENT		

Medical Executive Committee - Approved By:	Approval Date:
Board of Managers — Approved By:	Approval Date: