UNIVERSITY OF MARYLAND MEDICAL CENTER
APPLICATION FOR VASCULAR SPECIALIST

NAME: _____ **DATE:** _____

DEPT/DIVISION: _____

Certification or Eligibility by one of the following required (please check all that apply):

___ **American Board of Radiology with additional completion of Interventional Radiology fellowship**
___ **American Board of Internal Medicine with additional eligibility/certification in Cardiovascular Medicine**
___ **American Board of Surgery with additional completion of Vascular Surgery Residency**

PROCEDURES	**To Be Completed By Applicant**			**Recommendations (To be completed by Section Chief)** Initial if Yes Write "Not Approved" if No
	Criteria* Number of procedures	**Number done in Training/ Practice**	**Check if Requested**	
Category 1 - Basic Diagnostic: to be eligible, applicant must be Board Certified or a candidate for Board Certification as delineated in above reference specialties.				
Diagnostic Peripheral Angiography	**100**			
Category 2 - Basic Peripheral Endovascular Interventions: to be considered applicant must first meet Category 1 eligibility requirements.				
Peripheral Percutaneous Transluminal Interventions	**50**			
Category 3 – Advanced Endovascular Therapeutic Interventions:** to be considered, applicant must first meet Category 1and 2 eligibility requirements.				
Thrombolytic Therapy	**10**			
Aortic Endografts	**10**			
Extracranial carotid interventions	**10**			
Renal interventions	**10**			

At least half of each number must have been performed with applicant as primary operator.
***** Applicants for Advanced procedures must have approved credentials for Basic procedures***

NOTE: All physicians must be credentialed for moderate (conscious) sedation. Please complete appropriate portion on your departmental delineation of privileges.

After completing this form, please return it to Medical Staff Services, 110 S. Paca Street, 8th Floor, Baltimore, MD 21201.

_____ _____
Applicant's Signature Date

_____ _____
Section Chief Date

_____ _____
Department Chair Date

_____ _____
Vascular Center Committee Date

_____ _____
Applicant's Confirming Signature *(required if any requested privilege is not approved)* Date