

**ATRIUM HEALTH ANSON  
REAPPOINTMENT  
DELINEATION OF PRIVILEGES  
SPECIALTY OF ANESTHESIA**

I have reviewed the DOP/Roster provided to me by MSS and confirm as indicated below:

- My DOP is accurate and reflects privileges relevant to my current practice
- I have listed privileges that should be removed:

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***IF YOUR ROSTER INDICATES THAT YOU HOLD ANY OF THE PRIVILEGES HIGHLIGHTED BELOW, YOU MUST PROVIDE THE MAINTENANCE CRITERIA AS DESCRIBED, IN ORDER TO MAINTAIN THE PRIVILEGE. THIS ATTESTATION AND ANY MAINTENANCE CRITERIA MUST BE RETURNED TOGETHER.***

**N/A - NO MAINTENANCE CRITERIA**

**STOP:**

**UNLESS YOU ARE REQUESTING NEW PRIVILEGES, YOU DO NOT NEED TO GO BEYOND THIS POINT.**

**Carolinas HealthCare System Anson**

**Department of: Medicine**  
**Specialty: Anesthesia**

\_\_\_\_\_  
Print Name

Spinal anesthesia

**Privilege/Procedure**

Emergency Tracheotomy  
Epidural  
General Anesthesia - Inhalation, Endotracheal  
General Anesthesia, IV or Inhalation  
Local Infiltration  
Moderate Conscious sedation  
PAIN MANAGEMENT  
Regional Anesthesia; Field Block

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date