Application for Laser Use at Boston Medical Center

PROJECT TITLE

APPLICANT

Last Name **First Name** **Email**

Specialty/Department **Campus**

Chief of Service

ATTACHED DOCUMENTATION OF TRAINING AND COMPETANCE

- ☐ Verification of laser training from residency program director
- ☐ Certificate of attendance at an ACCME-approved laser training course
- ☐ Letter of recommendation from an expert practitioner of preceptorship experience AND proof of BMC Laser Safety training
- ☐ Documentation of laser privileges and laser surgery experience at another JCAHO-accredited hospital
- ☐ Other (attach description)

Type of laser(s) for which privileges are requested:

APPLICANT SIGNATURE

Name (printed, if not electronic signature) Date

Signature / Electronic Signature

RECOMMENDATION OF LASER PRIVILEGES

I recommend that laser privileges be granted:

CHAIRMAN, LASER ADVISORY COMMITTEE

Must be unanimously approved by a quorum of the committee

Name (printed, if not electronic signature) Date

Signature / Electronic Signature

CHIEF OF SERVICE

Name (printed, if not electronic signature) Date

Signature / Electronic Signature

Please return completed application with documentation to the Medical Affairs Office, (617-414-5529)