

**PROGRAM FLEXIBILITY REQUEST FOR CARDIAC CATHETERIZATION
LABORATORIES**

Name of Hospital:	
Address:	
Telephone Number:	
FAX Number or Email Address:	

Please provide a detailed list of the additional procedures requested for program flexibility in the cardiac catheterization laboratory space.

Indicate (check) hospital’s service below:

___ GACHS **without** a licensed cardiovascular surgery service are limited to requesting additional diagnostic cardiac procedures and non-cardiac interventional procedures. Please provide additional sheets if needed.

___ GACHS **with** a licensed cardiovascular surgery service may include additional cardiac procedures as well as non-cardiac interventional procedures. Please provide additional sheets if needed.

REQUESTED PROCEDURES FOR PROGRAM FLEXIBILITY

To the best of my knowledge, I hereby attest that the cardiac catheterization laboratory space is in compliance with all applicable Title 22 and Title 24 regulations concerning the safe operation of an operating room environment.

Print Name and Title Phone Number: _____	Signature _____	Date _____
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