

Presidio Surgery Center

A California Pacific Medical Center Affiliate

NEUROLOGICAL SURGERY - Delineation of Privileges

I, _____ hereby request privileges in the specialty of NEUROLOGICAL SURGERY as indicated. I understand that privileges requested may differ from approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

Please indicate by a check in the requested column those privileges, commensurate with your clinical ability, training and experience, for which you are applying. Please check each requested box **individually**.

DESCRIPTION OF PRIVILEGE:	Requested	A= Approved NA= Not Approved AP= Approved w/proctor
History and Physical		
Carpal Tunnel Release		
Anterior Cervical Fusion		
Posterior Cervical Discectomy		
Cranioplasty		
Kyphoplasty		
Lumbar Laminectomy, Laminotomy, Discectomy		
Removal Lipoma		
Removal of Peripheral Nerve Tumor		
Sural Nerve Biopsy		
Ulnar Nerve Neurolysis/transposition		
Vagus Nerve Simulator Implantation		
Vertebroplasty		
OTHER		
• Operate & Interpret Fluoroscopy – certificate required		
• Use of Intra-operative Microscope		
• Topical Anesthesia		
• Local Anesthesia		

Revised: 8/06

Your initials as used in Medical Record: _____

Physician Signature

Date

APPROVAL	
Comments:	
Medical Director /Chair MEC	Date