

ORTHOPEDICS

DELINEATION OF PRIVILEGES

I, _____, hereby request privileges in the specialty of **ORTHOPEDICS** as indicated. I understand that privileges requested may differ from those 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 which are commensurate with your clinical ability, training and experience for which you are applying.

PRIVILEGES	FACILITY	
	Requested	A= Approved AP= Approved w/proctoring NA= Not Approved
<ul style="list-style-type: none"> Evaluation and diagnosis of medical conditions to determine need for surgical intervention with regard to appropriate consultation when prudence and good medical care so require. 		
ACL reconstruction		
PCL reconstruction		
Amputation finger/toe		
Arthrodesis		
Arthroscopy : Knee; Shoulder; Ankle		
Arthroscopy : Elbow** ___ Wrist** ___ Hip** ___		
Arthroplasty		
Arthrotomy		
Bone grafts		
Bunionectomy		
Bursectomy		
Carpal tunnel release - Open		
Carpal tunnel release - Endoscopic **		
Cartilage transplantation **		
Cast application		
Closed reduction		
De Quervain's release		
Excision bony lesion		
Ganglionectomy		
Hammertoe repair		
Hardware removal		
I&D abscess		
Joint and tendon prosthesis		
Ligament repair		
Manipulation of joint		
Meniscal transplantation **		
Meniscal Repair		
Meniscectomy		
Neuroma excision		
Open reduction with or without reduction		
Osteotomy		

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	FACILITY	
	Requested	A= Approved AP= Approved w/proctoring NA= Not approved
Synovectomy		
Shoulder Resurfacing		
Tendon repair		
Tenolysis		
Trigger finger release		
Tumor excision		
Unispacer		
<u>Hand Surgery ***</u>		
Complex intra-articular small joint fractures		
Dupuytren's partial fasciectomy		
Flexor tendon repair – fingers		
Peripheral nerve surgery		
Prosthetic joint replacements		
Skin graft and flaps		
Tendon transfers		
<u>Spine Surgery**</u>		
Anterior cervical fusion		
Discectomy:		
• Cervical, open		
• Lumbar, open		
• Percutaneous		
Lumbar Laminectomy; Laminotomy		
<u>Kyphoplasty</u>		
<u>Vertebroplasty</u>		
<u>Other</u>		
Operate & Interpret Fluoroscopy (certificate required)		
Extracorporeal shockwave therapy (certificate required)		
Topical anesthesia		
Local anesthesia		

** Include documentation of continuing education/training.

*** Requires a Hand Fellowship

Your initials as used in Medical Records _____

Your signature as used in Medical Records _____

Physician

Date

Approval/Comments: _____

Special Rep/ Medical Director

Date