

## CRITERIA FOR GRANTING ORTHOPEDIC PRIVILEGES

Please review these classifications carefully to determine those privileges for which you are qualified. Indicate your request on the following sheet. If you feel that special training/experience qualifies you for advanced privileges, please contact the appropriate department chairman. Physician admit and treat without limitation.

### **CLASS I**

**CRITERIA FOR GRANTING** - Physicians must have satisfactorily completed a residency in Orthopedic Surgery and be eligible for/or are currently certified by the American Board of Orthopaedic Surgery.

### **CLASS II**

**CRITERIA FOR GRANTING** - Physicians must meet criteria for Class I and in addition, must have satisfactorily completed a fellowship in the appropriate subspecialty and/or attended certified "hands-on" courses relevant to the procedure, and/or have documented training of such in residency.

**CLASS REQUESTING: CLASS I \_\_\_\_\_**

<b><u>PRIVILEGES REQUESTED</u></b>	<b><u>APPROX. # PERFORMED LAST 2 YEARS</u></b>	<b><u>APPROVED AND/OR COMMENTS</u></b>
_____ AMPUTATIONS - SIMPLE (FINGERS, TOES)	_____	_____
_____ AMPUTATIONS - MAJOR	_____	_____
_____ ARTHRODESIS - ALL JOINTS	_____	_____
_____ ARTHROTOMY - ALL JOINTS	_____	_____
_____ JOINT RESECTION	_____	_____
_____ JOINT REPLACEMENT	_____	_____
_____ I & D OSTEOMYELITIS, ABSCESS	_____	_____
_____ BONE GRAFT - ALL BONES	_____	_____
_____ OPEN-REDUCTION W/ FIXATION DEVICE _____	_____	_____
_____ CLOSED-REDUCTION WITH/WITHOUT FIXATION	_____	_____

<b><u>PRIVILEGES REQUESTED</u></b>	<b><u>APPROX. # PERFORMED LAST 2 YEARS</u></b>	<b><u>APPROVED AND/OR COMMENTS</u></b>
_____ SOFT TISSUE LACERATION REPAIR WITH/ WITHOUT TENDON, BLOOD VESSEL, NERVE	_____	_____
_____ EXCISION GANGLIONS, TUMORS, ETC.	_____	_____
_____ REPAIR TENDONS - PRIMARY OR SECOND	_____	_____
_____ HAND SURGERY - SIMPLE (CARPAL TUNNEL, ORIF METACARPAL FRACTURES, LIMITED FUSIONS, ETC.)	_____	_____
_____ BUNIONECTOMY, CLAW TOES, HAMMER TOES	_____	_____
_____ TENDON SUGERY - REPAIR, TRANSPLANT GRAFT	_____	_____
_____ SKIN GRAFTS	_____	_____
_____ APPLICATION OF EXTERNAL FIXATOR	_____	_____
_____ LAMINECTOMY FOR DISC REMOVAL	_____	_____
_____ SPINAL FUSION WITH OR WITHOUT GRAFT	_____	_____
_____ ARTHROSCOPIC SURGERY	_____	_____
_____ BONE BIOPSY/EXCISIONS	_____	_____

**CLASS REQUESTING: CLASS II \_\_\_\_\_**

**SPECIAL PROCEDURES**

<b><u>PRIVILEGES REQUESTED</u></b>	<b><u>APPROX # PERFORMED LAST 2 YEARS</u></b>	<b><u>APPROVED AND/OR COMMENTS</u></b>
_____ HAND SURGERY - COMPLEX (TENDON TRANSFERS, TENDON TRANSPLANTS, SILASTIC IMPLANTS, COMPLEX FUSIONS, ETC.)	_____	_____
_____ SCOLIOSIS SURGERY	_____	_____
_____ SPINE TRAUMA SURGERY	_____	_____
_____ RECONSTRUCTIVE PEDIATRIC HIP SURGERY	_____	_____
_____ LEG LENGTHENING AND/OR SHORTENING	_____	_____
_____ ARTHROSCOPIC LIGAMENT RECONST	_____	_____
_____ LASER ARTHROSCOPY	_____	_____
_____ MIDAS REX PNEUMATIC EQUIPMENT	_____	_____

**MISCELLANEOUS**

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

On the basis of my training and experience, I am qualified to exercise and request the privileges which I have checked.

I have not requested privileges for any procedures for which I am not qualified. I am familiar with the laws of the State governing the practice of medicine and pledge to abide by these laws.

**PRIVILEGES APPROVED:  AS REQUESTED  AS MODIFIED BELOW**

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

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chair, Surgery Department

\_\_\_\_\_  
Date