

CRITERIA FOR GRANTING GENERAL SURGERY PRIVILEGES

Please review these categories carefully to determine those privileges for which you are qualified. Indicate your request below by checking the appropriate category. If you feel that special training or experience qualifies you for advanced privileges, please contact the surgery department chair.

MINIMAL FORMAL TRAINING REQUIREMENTS:

Physicians requesting privileges should have successfully completed an approved Surgery Residency Program (of their specialty) and be board certified or eligible in their surgical specialty.

PROCTORING REQUIREMENTS: *In accordance with the Medical Staff Bylaws and the requirements of the Joint Commission on Accreditation of Healthcare Organizations, each new applicant and reappointee (asking for new privileges) to the medical staff of Foothill Presbyterian Hospital must have a minimum of six cases proctored. Three must be proctored by an Active or Courtesy staff member of the surgery department and an additional three may be accepted from another facility, if proctored by a member of the FPH medical staff.*

We will appreciate your assistance and cooperation in ensuring that this is accomplished. To assist us, we are requesting that for your first six cases or until otherwise notified, you obtain a proctor for your surgical cases. Your proctor is named in your "Welcome to the Staff" letter. A list of other available proctors is attached for your convenience. You should have no more than one-third of your proctored cases proctored by an associate in your office.

The proctored cases should be representative of the privileges you are requesting in your specialty. If you are unable to obtain a proctor, please call the Medical Staff Office and they will be happy to assist you. In the case of an emergency operative procedure, you may proceed without a proctor, only with the approval of the chief of your department or his or her designee.

Please be aware that proctors may intervene regarding proposed treatment during a procedure if they deem in their judgment that it is absolutely necessary. On completion of the required number of proctored cases, the surgery department will review and evaluate these reports. You will be advised of the decision regarding your satisfactory completion of proctoring or if there will need to be additional proctoring requirements. We are sure you understand the need to require your cooperation in these efforts. These are not only mandated requirements, but they are essential to the maintenance of the quality of care established by the medical staff at Foothill Presbyterian Hospital. Again, we appreciate your assistance in this matter.

If you have any questions regarding these proctoring requirements, please do not hesitate to contact the Medical Staff office at (626) 857-3241.

We welcome you.

Name: _____

Appointment/Reappointment: A minimum of three (3) cases of any of the following elective procedures **MUST** be proctored by a member of the Active Staff who has been granted the privilege.

Reappointment: A minimum of three (3) cases of any of the following elective procedures **MUST** be performed within the past two years. If this is not met, the request will be evaluated and monitoring may be re-assigned.

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	CORE GENERAL SURGERY PRIVILEGES	APPROVED	DENIED
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These procedural privileges are customarily performed by board certified, board eligible or fully trained general surgeons;

Documentation of specific training and current competence in core procedural privileges may be required;

Core Procedural Privileges have no asterisk.

REQUESTED	# PERFORMED IN LAST 2 YEARS	ADVANCED GENERAL SURGERY PRIVILEGES	APPROVED	DENIED
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These procedures may be performed by board certified, eligible or fully trained general surgeons;

Advanced procedure privileges required documentation of specific training and current competence when requested by any surgeon;

Advanced procedural privileges are denoted by one asterisk (*). Please review the attached Critical Sheet for current competence and proctoring requirements.

REQUESTED	# PERFORMED IN LAST 2 YEARS	Abdominal & Gastrointestinal	APPROVED	DENIED
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Abdominal Resection

Anterior Resection

Appendectomy/Meckel's

Diverticulectomy

Colon Resection

***Complex anorectal procedure**

Drainage of major abscess

Enterolysis

Exploratory Laparotomy

Anoplasty

Anal Fissurectomy

Anal Fistulectomy

Gastric Resection

Gastric Ulcer Surgery

Gastroenterostomy

Gastrorrhapy

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Abdominal & Gastrointestinal cont.	APPROVED	DENIED
<input type="checkbox"/>	_____	Hemorrhoidectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Hiatal hernia repair, anti-reflux Procedures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Ileal reservoir or conduit	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Paracentesis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Pilonidal cyst excision	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Pyloromyotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Pyloroplasty w/vagotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Retroperitoneal Exploration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Small Bowel resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Staging Laparotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Common Bile Duct Exploration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Hepatic Biopsy/Mass Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Nissen Fundoplication	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Heller Myotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Gastro-jejunal Bypass	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Roux-n-Y	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Graham patch for perforated Duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Vagotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Small Bowel Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Ileostomy creation & takedown	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Iatrogenic Enterotomy Repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Intra-abdominal mass biopsy/ Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Transanal excision of neoplasm	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Breast	APPROVED	DENIED
<input type="checkbox"/>	_____	Axillary node dissection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Breast Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Stereotatic Breast Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Sentinel Lymph Node Biopsy	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Embolectomy	APPROVED	DENIED
<input type="checkbox"/>	_____	*Arterial	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Graft	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Venous	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Esophagus	APPROVED	DENIED
<input type="checkbox"/>	_____	Esophageal anastomosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Esophageal dilation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Esophagotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Esophagectomy	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Head & Neck	APPROVED	DENIED
<input type="checkbox"/>	_____	Cervical lymph node biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Needle biopsy-thyroid	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Parathyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Thyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Liver, Biliary Tract, Pancreas	APPROVED	DENIED
<input type="checkbox"/>	_____	Cholecystectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Cholangiogram and CBD Exploration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Choledochostomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Liver Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Pancreas Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Pancreatectomy (partial or complete)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Transduodenal sphincteroplasty	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Lymphatic & Spleen	APPROVED	DENIED
<input type="checkbox"/>	_____	Excision of lymph node	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Lymphadenectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Splenectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Splenic Repair	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Non-Coronary Endovascular	APPROVED	DENIED
<input type="checkbox"/>	_____	Thrombolysis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Thrombectomy	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Repair of Hernia	APPROVED	DENIED
<input type="checkbox"/>	_____	Epigastric	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Femoral	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Inguinal	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Umbilical	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Ventral	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Sympathectomy	APPROVED	DENIED
<input type="checkbox"/>	_____	Cervical	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Lumbar	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Skin & Subcutaneous tissue	APPROVED	DENIED
<input type="checkbox"/>	_____	Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Excision of cyst or lesion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Skin grafts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Incision & drainage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Secondary wound closure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Suture repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Fasciotomy	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Thoracic	APPROVED	DENIED
<input type="checkbox"/>	_____	Thoracoscopy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Thoracostomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Thoracotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Partial pneumonectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Total Pneumonectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Lung biopsy	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Urology	APPROVED	DENIED
<input type="checkbox"/>	_____	Adrenalectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Hydrocele	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Cystotomy repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Pelvic node dissection	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Vascular Access	APPROVED	DENIED
<input type="checkbox"/>	_____	Arterial lines-peripheral	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Central Venous Lines	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Intra-abdominal vascular bypass	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Lower extremity vascular bypass	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Upper extremity vascular bypass	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Other Modalities Endoscopic Procedures	APPROVED	DENIED
<input type="checkbox"/>	_____	*Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Percutaneous Endoscopic Gastrostomy Tube	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Laser Procedures	APPROVED	DENIED
<input type="checkbox"/>	_____	*KTP	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Other	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Laparoscopic Procedures	APPROVED	DENIED
<input type="checkbox"/>	_____	*Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Cholecystectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Hepatic Biopsy/Mass Biopsy	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Advanced Laparoscopic Procedures	APPROVED	DENIED
<input type="checkbox"/>	_____	*Lysis of Adhesions	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Intra-abdominal mass biopsy/ resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Herniorrhaphy Groin Ventral	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Splenectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Adrenalectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Common bile duct exploration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Common bile duct anastomosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Vagotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Heller Myotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Nissen Fundoplication	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Graham patch for perforated Duodenal Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Gastro-jejunal bypass	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Roux-n-Y	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Small Bowel Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Ileostomy creation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Ileostomy takedown	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Colostomy creation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Colostomy takedown	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Right Hemicolectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Mobilization of splenic flexure w/wo left hemicolectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Anterior resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Abdominopericreal resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	*Other _____	<input type="checkbox"/>	<input type="checkbox"/>

I certify that I have had the necessary training and experience to perform the procedures that I have requested. All privileges delineated have been individually considered and have been recommended based upon practitioner's specialty, licensure, specific training, experience, health status, current competency and peer recommendations.

PRIVILEGES APPROVED: AS REQUESTED AS MODIFIED BELOW

 SIGNATURE OF APPLICANT

 DATE

 CHAIR, SURGERY DEPARTMENT
 fphgs 4/09

 DATE