

*****SAMPLE*****
SURGERY DEPARTMENT - GENERAL SURGERY PRIVILEGE FORM

APPLICANT: _____ DATE: _____

BOARD CERTIFICATION: _____ DATE: _____

PLEASE INDICATE YOUR PRIVILEGE PREFERENCE BELOW BY CHECKING THE APPROPRIATE BOX:

- Full surgical privileges with authorization to admit patients and furnish care as indicated on this form.
- Consulting privileges only in the areas indicated on this form.
- Other privileges only for assisting at surgery or following patients referred by active staff members for the areas indicated on this form.
- Sedation - I will abide by the requirements as outlined in the sedation protocol.

CRITERIA FOR APPLYING FOR PRIVILEGES:

PRIVILEGE CATEGORIES

PRIVILEGES

CATEGORY 1

USUAL AND CUSTOMARY PRIVILEGES

1. Board certification or successful completion of an approved surgery training program/OR
2. Experience and demonstrated competence in Pediatric Surgery.
3. Additional documentation of experience and demonstrated competence may be required.
4. Privileges will be proctored in accordance with the medical staff Bylaws and department/section proctoring protocol.

CATEGORY 2

ADVANCED PRIVILEGES (Procedures performed, requiring special expertise and/or documented special training and/or certification when it exists and as detailed on the attached pages)

1. Board certification or successful completion of an approved surgery training program/AND
2. Experience and demonstrated competence in Pediatric Surgery/AND
3. Certification of training director verifying experience and competence in privileges requested.
4. Additional documentation of experience and demonstrated competence may be required.
5. Privileges will be proctored in accordance with the medical staff Bylaws and department/section proctoring protocol.

Procedure List - This is a representative, but of necessity not complete, list of procedures identified for this specialty. It is assumed that other procedures and problems of similar complexity will fall within the identified privileges. The list provided on page 2 is not intended to be exclusive of any additional procedures performed by the physician in this specialty. Requests for privileges not generally documented with evidence of appropriate training and experience.

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(GENERAL SURGERY PRIVILEGES ARE LIMITED TO PROVIDING CARE TO PATIENTS OVER THE AGE TWO [2] WITH THE EXCEPTION OF THE PRIVILEGES FOR EVALUATION OF TRAUMA PATIENTS)

DESCRIPTION OF PRIVILEGES
 YES OR NO COLUMN MUST BE CHECKED

CATEGORY 1 PRIVILEGES

General Cognitive

			APPROVED W/ CONDITIONS (SEE BELOW)	DEFERRED (SEE BELOW)	DOCUMENTATION NOT RCVD; VOLUNTARY WITHDRAWAL
A. <u>GENERAL COGNITIVE</u>					
YES	NO				
<input type="checkbox"/>	<input type="checkbox"/>	1. Admitting privileges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2. Assisting in Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	3. Evaluation of Trauma Patient NOT AGE SPECIFIC (REQUIRES REVIEW AND APPROVAL IN ACCORDANCE WITH TRAUMA PROTOCOLS FOR ADMISSION ON TRAUMA CALL SCHEDULE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	4. Sedation (PROTOCOL FOR SEDATION AND CREDENTIALING REQUIREMENTS WILL BE FORWARD TO THOSE REQUESTING THIS PRIVILEGE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. <u>MINOR/MAJOR GENERAL PROCEDURES**</u>					
<input type="checkbox"/>	<input type="checkbox"/>	1. Closure of laceration, complex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2. Closure of laceration, simple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	3. Excision benign lesions skin and subcutaneous tissue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	4. Excision of nail and nail matrix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	5. I&D Abscess, superficial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	6. Medical/Surgical Treatment of Abscesses (Superficial)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	7. Pedicle flaps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	8. Skin graft - full thickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	9. Skin graft - split thickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. <u>HEAD AND NECK**</u>					
<input type="checkbox"/>	<input type="checkbox"/>	1. Cervical lymphnode biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. <u>ABDOMEN**</u>					
<input type="checkbox"/>	<input type="checkbox"/>	1. Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2. Herniorrhaphy/inguinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	3. Herniorrhaphy/umbilical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	4. Herniorrhaphy/ventral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. <u>LAPAROSCOPIC SURGERY</u> (see Laparoscopic Surgery Privilege Protocol Attached)**					
<input type="checkbox"/>	<input type="checkbox"/>	1. Assisting Privileges only for other laparoscopic procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2. Laparoscopic appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I CERTIFY THAT I HAVE HAD THE NECESSARY TRAINING AND EXPERIENCE TO PERFORM THE PROCEDURES I HAVE REQUESTED.

APPLICANT SIGNATURE _____ DATE: _____

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APPROVALS: All privileges delineated have been individually considered and have been recommended based upon the physician's specialty, licensure, specific training, experience, health status, current competence and peer recommendations.

APPLICANT MAY PERFORM PRIVILEGES AS INDICATED.

FOR LIMITATIONS/DEFERRED PRIVILEGES, PLEASE SPECIFY: _____

CHIEF, PEDIATRIC SECTION

DATE: _____

CHAIR, SURGERY DEPARTMENT

DATE: _____

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CRITERIA SURGERY DEPARTMENT TRAINING/EXPERIENCE REQUIREMENTS FOR GENERAL SURGERY PRIVILEGES		
PRIVILEGES	INITIAL APPOINTMENT	EVERY 2 YEARS FOR REAPPOINTMENT
Minor/Major General procedures Head & Neck Procedures Abdomen Procedures	Documentation of satisfactory performance in 5 cases representative of privileges requested.	Documentation of having performed at least 1 procedure every 2 years for each section of privileges (eg, 1 from Minor/Major General procedure; 1 from Abdomen procedures)
Laparoscopic surgery	Documentation of satisfactory performance in 5 cases.	Documentation of satisfactory performance of 1 case every 2 years.