

DEPARTMENT: SURGERY

SECTION: PLASTIC SURGERY

Name: _____
(please print)

Qualifications: EDUCATION / TRAINING / EXPERIENCE

Core privileges in plastic surgery require a MD or DO and current certification or active participation in the examination process leading to certification in plastic and/or reconstructive surgery by the American Board of Plastic Surgery or the American Osteopathic Board of Surgery; successful completion of an ACGME- or AOA-accredited residency in plastic and reconstructive surgery that qualifies for Board Certification. Board certification by ABU or AOBU in Plastic Surgery is required within five years of appointment to medical staff per the Medical Staff Bylaws unless practiced 25 years or greater in respective specialty.

PRIVILEGING

As documented by my experience and training on the Application for Appointment/Reappointment to the Medical Staff, I request privileges as indicated below.

Applicant: Place a check mark and initial in the (R) column for each privilege requested. For all Category II Special Privileges, current case logs indicating the specific procedure(s) requested **MUST** be submitted for consideration of these special privileges. Applicants may be asked to provide additional documentation of the number and types of hospital cases during the past 24 months as apart of the privileging process.

CHAIRMAN: (A) =Recommended as Requested (C) = Recommended with Conditions (N) =Not Recommended

| (R) | (A) | (C) | (N) | CATEGORY I: PLASTIC SURGERY CORE PRIVILEGES | <i>Department Chair Initials</i> |
|-----|-----|-----|-----|---|----------------------------------|
| | | | | Privileges to admit, consult, evaluate, diagnose, treat, and perform surgical procedures for patient--except as specifically excluded from practice and except for those advanced procedure privileges listed below—presenting with both congenital and acquired defects of the body’s soft tissue. Core privileges include, but are limited to, treatment of skin neoplasia; diseases and trauma; surgery of the breast, including breast reduction/augmentation and breast reconstruction; treatment of facial diseases and any injuries including maxillofacial structures; reconstruction of congenital and acquired defects of the trunk and genitalia; liposuction; hand surgery; and cosmetic surgery. | |
| | | | | Newborn & infants to 2 years | |
| | | | | Children 2 years to 14 years | |
| | | | | Adolescents 14 to 18 years | |
| | | | | Adults 18 years and greater | |

Clinical Privileges in **Plastic Surgery**

DEPARTMENT: SURGERY

SECTION: PLASTIC SURGERY

Name: _____
(please print)

| (R) | (A) | (C) | (N) | CATEGORY II: PLASTIC SURGERY SPECIAL PRIVILEGES | | | Department Chair Initials |
|-----|-----|-----|-----|--|--|-------------------------------|------------------------------|
| | | | | <i>Must meet the requirements outlined for Category I AND demonstrate proof of additional training, clinical competence and/or experience, with documentation of such additional qualifications.</i> | | | |
| | | | | Privilege Requested | Required Previous Experience | Reappointment Criteria | |
| | | | | Ultrasonic assisted liposuction | <i>For special privilege, all the qualifications for plastic surgery, plus documentation of current training and/or experience in the management of specialty intervention or evidence of special certification</i> | | |
| | | | | Endoscopic Procedures | <i>For special privilege, all the qualifications for plastic surgery, plus documentation of current training and/or experience in the management of specialty intervention or evidence of special certification</i> | | |
| | | | | Arthroscopic Surgery | <i>For special privilege, all the qualifications for plastic surgery, plus documentation of current training and/or experience in the management of specialty intervention or evidence of special certification</i> | | |
| | | | | Replantation surgery | <i>For special privilege, all the qualifications for plastic surgery, plus documentation of current training and/or experience in the management of specialty intervention or evidence of special certification</i> | | |
| | | | | Administration of Moderate sedation | <i>For initial clinical privilege request, physicians must read the Moderate Sedation Self Directed Learning Activity, take and pass a post test with a passing score of 80% or better and documentation current ACLS certification or document successful demonstration of airway management, oral airway insertion and ambu bag usage.</i> | | |

DEPARTMENT: SURGERY

SECTION: PLASTIC SURGERY

Name: _____
(please print)

PRIVILEGE CRITERION

Provisional Privileges: *Provisional privileges, during the first 6 months of practice of the procedure at Presbyterian Hospital of Rockwall, are conferred to facilitate the pursuit of full privileges at Presbyterian Hospital of Rockwall. With this classification, it is appropriate for the physician to assist in cases and complete any proctoring requirements to meet full privilege requirements for Presbyterian Hospital of Rockwall.*

Special procedures: *Unless otherwise set out in this document, successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship or other acceptable experience; and documentation of competence to obtain and retain clinical privileges as set forth in medical staff policies governing the exercise of specific privileges.*

Use of Laser: *Completion of a training course and documentation of case logs.*

Moderate Sedation: *For initial clinical privilege request, physicians must read the Moderate Sedation Self Directed Learning Activity, take and pass a post test with a passing score of 80% or better and documentation current ACLS certification or document successful demonstration of airway management, oral airway insertion and ambu bag usage.*

Observation / Proctoring Requirements: *Guidelines, scheduling, payment and approval process for the proctoring programs are defined in the Medical Staff policy.*

Reappointment Requirements: *Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Practice will be monitored for the first 12 months as per Joint Commission guidelines.*

Continuing Medical Education: *In compliance with Joint Commission standard the physician must participate in continuing medical education (CME) as per state licensure regulations, outlined by the medical staff by-laws rules and regulations.*

Participation in Societies: *Active participation in societies related to this field is also strongly recommended.*

Note: If any privileges are covered by an exclusive contractual agreement, physicians who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training and experience.

Clinical Privileges in **Plastic Surgery**

DEPARTMENT: SURGERY

SECTION: PLASTIC SURGERY

Name: _____
(please print)

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Presbyterian Hospital of Rockwall, and

- 1) I understand that:
 - a) In exercising any clinical privileges granted, I am constrained by any Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation and agree to be proctored.
 - b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.
- 2) I do attest that I have participated in continuing medical education activities related to the privileges I have requested.

Applicant Name – Printed

Signature

____/____/____
Date

DEPARTMENT CHAIRMAN RECOMMENDATION

I have reviewed the requested clinical privileges, as well as the appointment / reappointment application, performance improvement profile, and other pertinent appointment / reappointment information. Based on my review I propose the following:

| <input type="checkbox"/> Recommend | <input type="checkbox"/> Recommend with Conditions | <input type="checkbox"/> Not Recommended | <input type="checkbox"/> Deferred for Committee Discussion |
|------------------------------------|--|--|--|
| Comments: | | | |
| | | | |
| | | | |
| | | | |

Department Chairman Signature

____/____/____
Date

ACCEPTANCE AND APPROVAL

Credentials Chairman Signature

____/____/____
Date

President of Medical Staff Signature

____/____/____
Date