

**DEPARTMENT:** SURGERY

**SECTION:** ORTHOPEDIC SURGERY

Name: \_\_\_\_\_  
(please print)

**Qualifications: EDUCATION / TRAINING / EXPERIENCE**

Core privileges in Orthopedic Spine Surgery- Fellow require a MD or DO and successful completion of an American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery accredited post graduate training program. Currently a fellow in training program in orthopedic spine surgery with sponsorship by approved Member of the Medical Staff holding full orthopedic surgery spine privileges. All admissions must be made in conjunction with sponsoring attending physician.

**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)	<b>CATEGORY I: ORTHOPEDIC SPINE SURGERY- FELLOW CORE PRIVILEGES</b>	<b>Department Chair Initials</b>
				Privileges to co-admit with sponsoring physician, consult, evaluate, diagnose, and provide non-surgical and surgical care to patients and to correct or treat various conditions, illnesses, and injuries of the musculoskeletal system, except as specifically excluded from practice and except for those advanced procedure privileges listed below.	
				<b>ORTHOPEDIC SPINE</b> <b>Privileges to Assist Attending Orthopedic Spine Surgeon with the following procedures-</b> Disc surgery, cervical, thoracic and lumbar Fractures and dislocations of the spine Spinal Instrumentation Corrective and reconstructive surgery of the axial skeleton including posterior spinal fusion and posterior instrumentation Anterior spinal fusion in cervical dorsal or lumbar regions Scoliosis surgery and reconstruction of congenital spinal anomalies: posterior instrumentation, anterior fusions, including Dwyer instrumentation Rigid Spinal endoscopic surgery: cervical, thoracic, lumbar, Kyphoplasty Percutaneous vertebral body fracture reduction with inflatable bone tamp	
				<b>PEDIATRIC SPINE</b> <b>Privileges to Assist Attending Orthopedic Spine Surgeon with the following procedures-</b> __ Bone shortening procedures __ Bone lengthening procedures • Operative treatment of growth disturbances • Epiphyseodesis __ Developmental growth disturbances	

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				___ Reconstruction of non-spinal congenital musculoskeletal anomalies, pediatric: congenital dislocated hips, club foot, wry neck, scapular anomalies	
				<b>ORTHOPEDIC SPINE PAIN PROCEDURES</b> <b>Privileges to Assist Attending Orthopedic Spine Surgeon with the following procedures-</b> <b>ORTHOPEDIC SPINE PAIN PROCEDURES</b> - Epidurals Pain Pump -Epidural Injections -SI Joint Injections -Selective Nerve Root Blocks -Facet Injections -Peripheral Nerve Blocks -Spinal Cord Stimulators -Rhizotomy	

**PHYSICIAN RESPONSIBILITY:**

**Supervision:** The sponsoring attending physician is required to provide adequate supervision of the fellow initiating medical aspects of care. The fellows are not authorized for performing surgery independent of the sponsoring attending physician(s) and all cases must be posted by the attending physician.

**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

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**SPONSORING PHYSICIAN:**

I certify that the named fellow is competent to perform all delineated privileges as indicated above and I accept full responsibility for the actions of this fellow while in the performance of the privileges requested.

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_/\_\_\_\_/\_\_\_\_  
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"/> <b>Recommend</b> | <input type="checkbox"/> <b>Recommend with Conditions</b> | <input type="checkbox"/> <b>Not Recommended</b> | <input type="checkbox"/> <b>Deferred for Committee Discussion</b> |
|---|---|---|---|

Comments:


\_\_\_\_\_  
Department Chairman Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**ACCEPTANCE AND APPROVAL**

\_\_\_\_\_  
Credentials Chairman Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
President of Medical Staff Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date