

Clinical Privileges in **Orthopedic Surgery**

DEPARTMENT: SURGERY

SECTION: ORTHOPEDIC SURGERY

Name: _____
 (please print)

Qualifications: EDUCATION / TRAINING / EXPERIENCE

Core privileges in orthopedic surgery 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; OR successful completion of an ACGME or AOA accredited residency training program in orthopedics that qualifies for Board Certification. Board certification may be required within five years of appointment to medical staff based on departmental guidelines. Applicants shall submit a listing of all major operative or invasive procedures performed in the last 24 months.

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. Initial applicants must provide documentation of the number and types of hospital cases during the past 24 months.

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

Note: If recommendations for clinical privileges includes a condition, modification or not recommended, the specific condition and reason for same must be stated on the last page of this form.

(For office use only) **Initial** _____ **Renewal** _____ Effective ___/___/___ to ___/___/___

(R)	(A)	(C)	(N)	CATEGORY I: ORTHOPEDIC SURGERY CORE PRIVILEGES	Department Chair Initials
				Privileges to admit, 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.	
				Children 2 years to 14 years	
				Adolescents 14 to 18 years	
				Adults 18 years and greater	
				Orthopedic Core Privileges include: <ul style="list-style-type: none"> ▪ Amputation surgery, including immediate prosthetic fitting in the OR ▪ Arthrodesis, osteotomy and ligament reconstruction of the major peripheral joints ▪ Application of splints and casts ▪ Arthrography ▪ Arthrocentesis and injection of joints, bursae, and cysts ▪ Arthroscopy: <ul style="list-style-type: none"> ___ knee ___ hip ___ shoulder ___ wrist ___ ankle ___ elbow ▪ Soft tissue procedures including simple suture, debridement of wounds, excision of bursae, removal of foreign bodies, I&D of acute or chronic infections ▪ Biopsy and excision of tumors, soft tissue and bone, from extremities, back and neck, not requiring major bone or joint reconstruction ▪ Tendon fixation, suture and transplants ▪ Bone grafting procedures ▪ Arthrotomies of all joints ▪ Synovectomy any joint 	

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(R)	(A)	(C)	(N)	CATEGORY I: ORTHOPEDIC SURGERY CORE PRIVILEGES (continued)	Department Chair Initials		
				Orthopedic Core Privileges include: (continued) <ul style="list-style-type: none"> ▪ Hip and shoulder hemi-arthroplasty for hip and shoulder fractures ▪ Surgical correction of nerve entrapment syndromes ▪ Major arthroplasty including total replacement of <ul style="list-style-type: none"> __knee __hip __shoulder __elbow __ankle ▪ Repair or reconstruction of ligament ruptures, any joint ▪ Fasciotomy and/or fasciectomy ▪ Osteotomy any bone ▪ Closed reductions of all fractures and dislocations ▪ Open reduction of fractures and dislocations with or without internal fixation ▪ Excision of bones or portions of bone ▪ Sequestrectomy and saucerization of infected bone ▪ Fractures and dislocations of the pelvis and acetabula for stabilization and transportation ▪ Bone drilling operations ▪ Skin grafts as related to orthopedic problems ▪ Arthrodesis, any joint 			
				CATEGORY II: ORTHOPEDIC SPECIAL PRIVILEGES <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>	Department Chair Initials		
(R)	(A)	(C)	(N)	Privilege Requested	Required Previous Experience	Reappointment Criteria	Department Chair Initials
				ENDOSCOPIC ASSISTED CARPAL TUNNEL DECOMPRESSION	<ul style="list-style-type: none"> ▪ Qualifications for orthopedic surgery, plus documentation of current training and/or experience in invasive intervention. 		
				ORTHO HAND AND FOOT __Peripheral nerve repair __Neurography __Nerve transplants and neurolysis	<ul style="list-style-type: none"> ▪ Qualifications for orthopedic surgery, plus documentation of current training and/or experience in invasive intervention. 		
				VASCULAR GRAFTS OF THE HANDS AND FOREARM	<ul style="list-style-type: none"> ▪ Qualifications for orthopedic surgery, plus documentation of current training and/or experience in invasive intervention. 		

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(R)	(A)	(C)	(N)	CATEGORY II: ORTHOPEDIC SPECIAL PRIVILEGES(continued)			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>			
				<i>Privilege Requested</i>	<i>Required Previous Experience</i>	<i>Reappointment Criteria</i>	
				ORTHOPEDIC SPINE ___ 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	<ul style="list-style-type: none"> ▪ <i>Qualifications for orthopedic surgery, plus documentation of current training and/or experience in invasive intervention.</i> 		
				ORTHOPEDIC SPINE SPECIAL PROCEDURES 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	<ul style="list-style-type: none"> ▪ <i>Qualifications for orthopedic surgery, plus documentation of current training and/or experience in invasive intervention.</i> 		
				PEDIATRIC SPINE ___ Bone shortening procedures ___ Bone lengthening procedures <ul style="list-style-type: none"> • Operative treatment of growth disturbances • Epiphyseodesis ___ Developmental growth disturbances ___ Reconstruction of non-spinal congenital musculoskeletal anomalies, pediatric: congenital dislocated hips, club foot, wry neck, scapular anomalies	<ul style="list-style-type: none"> ▪ <i>Qualifications for orthopedic surgery, plus documentation of current training and/or experience in invasive intervention.</i> 		

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				CATEGORY II: ORTHOPEDIC SPECIAL PRIVILEGES(continued)			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>			
(R)	(A)	(C)	(N)	<i>Privilege Requested</i>	<i>Required Previous Experience</i>	<i>Reappointment Criteria</i>	
				ORTHOPEDIC SPINE PAIN PROCEDURES - Epidurals Pain Pump -Epidural Injections -SI Joint Injections -Selective Nerve Root Blocks -Facet Injections -Peripheral Nerve Blocks -Spinal Cord Stimulators -Rhizotomy	<ul style="list-style-type: none"> ▪ Qualifications for orthopedic surgery, plus documentation of current training and/or experience in invasive intervention. 		
				ORTHOPEDIC ONCOLOGY ___Reconstruction of bone and soft tissue after excision of major tumors or infections of the musculoskeletal system (limb salvage procedures)	<ul style="list-style-type: none"> ▪ Qualifications for orthopedic surgery, plus documentation of current training and/or experience in invasive intervention. 		
				HEMIPELVECTOMY; _____ CHEMONUCLEOLYSIS	<ul style="list-style-type: none"> ▪ Qualifications for orthopedic surgery, plus documentation of current training and/or experience in invasive intervention. 		
				ADMINISTRATION OF MODERATE SEDATION	<ul style="list-style-type: none"> ▪ 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. 		

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 anesthesiology 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 an approved 6 hour minimum CME course which includes training in laser principles of safety, basic laser physics, laser tissue interaction, discussions of the clinical specialty field and hands-on experience with lasers. A letter outlining the content and successful completion of course must be submitted, or documentation of successful completion of an approved residency in a specialty or subspecialty which included training in laser principles and safety, basic laser physics, laser tissue interaction, discussions of the clinical specialty fields and a minimum of 4 hours didactic and 2 hours hands-on experience with lasers.

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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 JCAHO guidelines.

Continuing Medical Education: In compliance with JCAHO 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.

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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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 / /