



**Core Privileges**  
**General Surgery Services**

**QUALIFICATIONS:**

- MD or DO with successful completion of an ACGME or AOA-accredited residency or fellowship program in general surgery;
- Current certification or active participation in the examination process leading to certification in general surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. The new applicant must pass the ABS Certifying Exam within 5-years after successful completion of the Qualifying Examination in Surgery. Once board certified, the applicant must be engaged in the maintenance of certification (ABS-MOC) process for retaining diplomate status.
- Documentation or attestation of current clinical practice experience with at least 100 surgical inpatients or outpatients within the past 24 months as attending physician. *Reappointments: please be prepared to provide a list of cases performed at facilities other than Teche Regional Medical Center if requested.*

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

(R)	<b>CORE PRIVILEGES:</b>	(A)	(C)	(N)	Condition/Reason(s)
	<p>Core privileges include the ability to admit, evaluate, diagnose, consult, provide pre-, intra-, and postoperative surgical care, and perform the following surgical procedures:</p> <ul style="list-style-type: none"> <li>• Conditions, illnesses and injuries of the Alimentary Tract</li> <li>• Abdomen and its contents</li> <li>• Breasts, skin and soft tissue, including breast biopsy</li> <li>• Head and Neck, including trauma, vascular, endocrine, congenital, and oncologic disorders – particularly tumors of the skin, salivary glands, thyroid, parathyroid, and oral cavity</li> <li>• Vascular system, <u>excluding</u> the intracranial vessels, the heart and those vessels intrinsic and immediately adjacent thereto.</li> <li>• Endocrine system, including thyroid, parathyroid, adrenal, and endocrine pancreas</li> <li>• Endoscopic procedures, including rigid &amp; flexible proctosigmoidoscopy, operative choledochoscopy, laryngoscopy, bronchoscopy, esophagoscopy, gastroscopy, PEG tube placement, colonoscopy, and peritoneoscopy</li> <li>• Basic laparoscopy, including diagnostic laparoscopic appendectomy, laparoscopic cholecystectomy, hernia</li> <li>• Surgical oncology, including coordinated multimodality management of the cancer patient by screening, surveillance, surgical adjunctive therapy, rehabilitation, and follow-up</li> <li>• Comprehensive management of trauma, including musculoskeletal, hand, and head injuries</li> <li>• Complete care of critically ill patients with underlying surgical conditions in the emergency room, and intensive care unit</li> <li>• Insertion and management of chest tubes and central venous catheters, pulmonary artery and arterial catheters</li> <li>• Lumbar puncture</li> <li>• Pericardiocentesis, tracheostomy, paracentesis, thoracentesis</li> </ul> <p><i>[ You may mark through any privilege you will not be doing at this facility and do not wish to request ]</i></p>				

	<b>SPECIAL / OTHER PROCEDURES:</b> [Documentation of formal training, and/or additional course work is required in the absence of evidence of current practice experience and utilization. Proctoring may be imposed at the discretion of the Service Chief]				
	<ul style="list-style-type: none"> <li>Advanced laparoscopic, including Nissens, adrenals, spleens, bowels, bariatric surgery</li> </ul>				
	<ul style="list-style-type: none"> <li>Administration of Conscious Sedation <i>[non-anesthesiologist physicians must be ACLS certified, pass proficiency exam, or receive training through residency program, documentation required]</i></li> </ul>				in accordance with hospital sedation policy
	<ul style="list-style-type: none"> <li></li> </ul>				
	<ul style="list-style-type: none"> <li></li> </ul>				
	<ul style="list-style-type: none"> <li></li> </ul>				
	<ul style="list-style-type: none"> <li></li> </ul>				

I have requested and agree to perform only those operative procedures in the specific areas for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise at Teche Regional Medical Center. I also acknowledge that my professional malpractice insurance extends to all privileges I have requested, and attest to meeting the minimum qualifications having performed over 100 surgical procedures in the past 24-months.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**I have reviewed the requested clinical privileges and supporting documentation and recommended the privileges as indicated above.**

\_\_\_\_\_  
Signature of Service or Department Chair

\_\_\_\_\_  
Date

**Board of Trustees' Decision**

*Teche Regional Medical Center's Board of Trustees*

**Does**

**Does not grant clinical privileges as requested**

(if "does not" grant, give reasons in letter to the applicant with a copy of privilege list)

\_\_\_\_\_  
Secretary, Board of Trustees

\_\_\_\_\_  
Date



**HEALTH STATEMENT**

**TO CHIEF OF SERVICE / CHIEF OF STAFF**

1. I HEREBY CERTIFY THAT I POSSESS THE NECESSARY COGNITIVE AND MOTOR SKILLS TO SAFELY PERFORM ALL PRIVILEGES REQUESTED AND DECLARE MYSELF TO BE FREE FROM ANY CONDITION, ILLNESS, OR INFECTIOUS DISEASE THAT COULD COMPROMISE PATIENT CARE OR MY ABILITY TO PERFORM THE PRIVILEGES REQUESTED.

YES  NO

2. IF NO, DO YOU HAVE A PHYSICAL OR MENTAL CONDITION OR ILLNESS (INCLUDING ANY CHEMICAL OR ALCOHOL DEPENDENCY) WHICH COULD AFFECT YOUR ABILITY TO EXERCISE THE CLINICAL PRIVILEGES REQUESTED WITHOUT SPECIAL ACCOMMODATIONS IN ORDER FOR YOU TO EXERCISE THE PRIVILEGES REQUESTED SAFELY AND COMPETENTLY? TO ANSWER THIS QUESTION APPROPRIATELY, PLEASE REPORT ANY CONDITION WHICH IS, OR MAY BE INFECTIOUS, COULD AFFECT MOTOR SKILLS, COGNITIVE ABILITY OR JUDGMENT, OR COULD POTENTIALLY ADVERSELY AFFECT YOUR ABILITY TO CARE FOR PATIENTS OR TO INTERACT APPROPRIATELY WITH OTHER CAREGIVERS.

YES  NO

If yes, please explain:

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3. HAVE YOU TESTED POSITIVE FOR THE TUBERCULIN SKIN TEST?  YES  NO

If yes, please give date of positive skin test. \_\_\_\_\_

If no, when was your last PPD test? \_\_\_\_\_

REGARDLESS OF HOW THIS QUESTION IS ANSWERED, THE APPLICATION WILL BE PROCESSED IN THE USUAL AND CUSTOMARY MANNER. IF YOU HAVE ANSWERED THIS QUESTION AFFIRMATIVELY AND ARE FOUND TO BE PROFESSIONALLY QUALIFIED FOR MEDICAL STAFF APPOINTMENT AND CLINICALLY COMPETENT TO PERFORM THE CLINICAL PRIVILEGES REQUESTED, YOU WILL BE GIVEN AN OPPORTUNITY TO MEET WITH THE EXECUTIVE COMMITTEE TO DETERMINE WHAT ACCOMMODATIONS, IF ANY, ARE NECESSARY TO ALLOW YOU TO PRACTICE SAFELY.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CHIEF OF SERVICE

\_\_\_\_\_  
DATE