



CORE PRIVILEGES
Orthopaedic Surgery

Qualifications: Successful completion of an ACGME or AOA-accredited orthopaedic residency or fellowship program, with current board certification or active participation in the examination process leading to certification in Orthopaedic Surgery by the American Board of Orthopaedic Surgery (ABOS) preferred, or the American Osteopathic Board of Orthopaedic Surgery.

Reappointments: Beginning in 2010, all diplomats with time limited certificates must be in compliance with the ABOS requirements of the Maintenance of Certification (MOC) program, and have documented current practice experience with at least 100 orthopedic inpatients or outpatients within the past 24 months as attending physician.

(R)= Recommended as Requested (A)=Approved as Requested (C)=Recommended with Condition(s) (N)=Not Recommended

Requested						
Yes	No		(R)	(A)	(N)	(C) Condition/Reason(s)
		CORE PRIVILEGES:				
		Privileges to admit, evaluate, diagnose, consult, and provide non-surgical and surgical care to correct or treat various conditions, illnesses, or injuries of the musculoskeletal system. Core privileges include the following procedures, unless otherwise not requested:				
		<ul style="list-style-type: none"> ▪ Arthroscopy ▪ Trauma, including multisystem trauma ▪ Hand and foot surgery in adults and children ▪ Athletic injuries, including arthroscopy ▪ Cast application, reinforcement and removal procedures ▪ Arthrocentesis ▪ Arthrodesis ▪ Arthroplasty ▪ Amputation of upper & lower extremities ▪ Orthotics and prosthetics ▪ Metastatic disease ▪ Biopsy of the musculoskeletal system ▪ Orthopaedic oncology ▪ Orthopaedic rehabilitation, including amputations, disarticulations, & post-amputation care ▪ Musculoskeletal imaging ▪ Incision/Excision Bone ▪ Debridement Open Fracture ▪ Removal Fixation Device ▪ Other Repair & Plastic Operations Bone ▪ Bone Graft ▪ Neoplasms ▪ Repair & Plastic Operations, Other Joints ▪ Suture and packing of wounds ▪ Z-Plasty for Scar or Web Contracture ▪ Free Skin Graft to hand ▪ Free Skin Graft to other sites ▪ Cutting, Prep, & Attachment of Pedicle Graft or Flap ▪ Wide or radical excision lesion of skin ▪ Other Operations Joint Structure ▪ Other Excision Joint Structures ▪ Reconstruction of congenital abnormalities ▪ Comprehensive Burn Management 				

Requested					
Yes	No		(R)	(A)	(N) (C) Condition/Reason(s)

		<ul style="list-style-type: none"> ▪ Excision, repair & reconstruction of nails and nail beds ▪ Open or closed treatment of skin lesions of palm & soles ▪ Auto, allo & xenografting of bone and ligaments ▪ Open reduction fractures or dislocations ▪ Division muscle, tendon & fascia ▪ Resection muscle, tendon, fascia and bursa ▪ Repair muscle, peripheral nerve, tendon, fascia ▪ Excision, repair, transplantation of tendon, peripheral nerve ▪ Other operations muscle, peripheral nerve, tendon, fascia and bursa ▪ Implantation of electrical muscle or nerve stimulators ▪ Closed reduction fractures or dislocation ▪ Administration of Conscious Sedation (<i>in accordance with hospital sedation policy</i>) <p><i>[You may mark through any privilege you will not be doing at this facility and do not wish to request]</i></p>				
		SPECIAL PROCEDURES:				<i>Documentation of additional training and experience required</i>
		Surgery of the spine, including disk surgery, fusion, spinal trauma, and spinal deformities				
		Spinal cord injury rehabilitation				

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 Teche Regional Medical Center.

Signature of Applicant

Date

Printed Name

Requested privileges reviewed and recommended 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:

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