

PLASTIC & RECONSTRUCTIVE SURGERY SERVICES

DELINEATION OF PRIVILEGES

NAME: \_\_\_\_\_

Privileges Requested

PLASTIC SURGERY

\_\_\_\_\_ Incision Skin and Subcutaneous Tissue \_\_\_\_\_  
 \_\_\_\_\_ Suture of Skin or Mucous Membrane \_\_\_\_\_  
 \_\_\_\_\_ Z-Plasty for Scar or Web Contracture \_\_\_\_\_  
 \_\_\_\_\_ Cleft Lip and Palate, Primary & Secondary \_\_\_\_\_  
 \_\_\_\_\_ Free Skin Grafts to Other Sites \_\_\_\_\_  
 \_\_\_\_\_ Dermabrasion \_\_\_\_\_  
 \_\_\_\_\_ Rhinoplasty - Reconstructive and Corrective \_\_\_\_\_  
 \_\_\_\_\_ Augmentation Mammoplasty \_\_\_\_\_  
 \_\_\_\_\_ Blepharoplasty \_\_\_\_\_  
 \_\_\_\_\_ Abdominal Lipectomy \_\_\_\_\_  
 \_\_\_\_\_ Repair Simple Lacerations of Hand, Finger Tips, etc. \_\_\_\_\_  
 \_\_\_\_\_ Repair, Extensive Hand Injuries, i.e., Crush Injuries \_\_\_\_\_  
 \_\_\_\_\_ Attachment Pedicle Grafts and Flaps to Hand and Other Sites \_\_\_\_\_  
 \_\_\_\_\_ Local Excision Lesions of Skin and Sub-cutaneous, Benign and Malignant \_\_\_\_\_

Wide or Radical Excision Lesions of Skin  
 Burn Management  
 Plastic Operation - Lip and Mouth  
 Free Skin Grafts to Hand  
 Preparation Pedicle Grafts and Flaps  
 Otoplasty - Reconstructive and Corrective  
 Meloplasty  
 Subcutaneous Mastectomy  
 Chemical Peel of Face  
 Suction Assisted Lipectomy or Lipolysis

RECONSTRUCTIVE HAND SURGERY

\_\_\_\_\_ Primary Tendon Repair \_\_\_\_\_  
 \_\_\_\_\_ Tendon Transfers \_\_\_\_\_  
 \_\_\_\_\_ Joint Replacements \_\_\_\_\_  
 \_\_\_\_\_ Secondary Tendon Repair and Tendon Grafts \_\_\_\_\_

Tendon Grafts  
 Transposition of Digits  
 Arthrodesis of Finger Joints  
 Other Reconstructive Hand Surgery

HEAD AND NECK SURGERY

\_\_\_\_\_ Reconstruction and Bone Grafting \_\_\_\_\_  
 \_\_\_\_\_ Other Reconstructive Surgery \_\_\_\_\_  
 \_\_\_\_\_ Ablation of Malignant Tumors of Head and Neck with Immediate or Staged Reconstruction to Include Flap \_\_\_\_\_

Parotidectomy

MAXILLO-FACIAL SURGERY

\_\_\_\_\_ Repair and Plastic Operations of Jaw \_\_\_\_\_  
 \_\_\_\_\_ Mentoplasty \_\_\_\_\_  
 \_\_\_\_\_ Closed Reduction Maxilla \_\_\_\_\_  
 \_\_\_\_\_ Closed Reduction Mandible \_\_\_\_\_  
 \_\_\_\_\_ Open Reduction Alveolus \_\_\_\_\_  
 \_\_\_\_\_ Facial Fractures. LeFort. I, II, III \_\_\_\_\_  
 \_\_\_\_\_ Surgical Correction Prognathism \_\_\_\_\_  
 \_\_\_\_\_ Orbital Decompression for Exophthalmos, etc. \_\_\_\_\_  
 \_\_\_\_\_ Surgical Repair of Skull Defects - Bone Grafting, etc. \_\_\_\_\_  
 \_\_\_\_\_ Open Reduction Malar, Zygoma and Arch, including Fixation \_\_\_\_\_  
 \_\_\_\_\_ Midfacial Osteotomies for Correction of Congenital Facial Anomalies \_\_\_\_\_  
 \_\_\_\_\_ Operation for Correction Cleft Palate and Related Secondary Operations \_\_\_\_\_

Reduction Dislocation of Jaw  
 Closed Reduction Malar, Zygoma and Arch  
 Open Reduction Maxilla  
 Open Reduction Mandible  
 Open Reductions and Fixation Complicated  
 Surgical Correction Hypertelorism  
 Free Tissue Transfer  
 Geniourinary Reconstruction

Admitting Privileges: Requested \_\_\_\_\_ Granted \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Applicant

Requested Privileges: Approved \_\_\_\_\_ Denied \_\_\_\_\_

Date: \_\_\_\_\_

Chief of Service



## 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