



Core Privileges

PODIATRY SERVICE

QUALIFICATIONS: Core privileges in podiatry require completion of a Podiatry Residency Program approved in and/or accepted by the Council of Podiatric Education and/or the American Board of Podiatric Surgery. Applicants must have demonstrated practice performance of at least 50 podiatric procedures within the past 24 months as primary surgeon and be board qualified or board certified by the ABPS. Podiatrists who are not board certified at the time of initial appointment will be afforded five (5) years to obtain board certification.

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

Requested						
Yes	No	[You may mark through any privilege you will not be doing at this facility and do not wish to request]	(R)	(A)	(N)	(C) Condition/Reason(s)
		CORE PRIVILEGES:				
		Privileges in podiatry service shall include the ability to work up, diagnose and admit patients with the concurrence of an active staff physician member of the medical staff responsible for recording the medical history and physical as well as the medical discharge summary, provide pre and postoperative care in the performance of surgical and non-surgical procedures to patients of all ages presenting with illness and injuries to the musculoskeletal system of the leg and foot within the scope of practice, including the provision of consultation and History and Physical for ASA Class I and II surgical candidates.				
		Core privileges in general podiatry include but are not limited to amputations (limited to toes) bunionectomies, arthroplasties, endoscopic plantar facial release, excision of bone and soft tissue tumors, fracture reduction, prosthetic implantation (forefoot, midfoot), surgery of the nails, tendon transfers/tenoplasties, incision and drainage of the forefoot and rearfoot.				
		Core privileges in rear foot and ankle podiatry include rear foot and ankle fixation/external fixation, fracture, osteotomies, arthrodesis, lateral ankle stabilization, ankle joint arthrotomy/arthroplasty, tendon transfer/tenoplasties, and excision of clinically benign bone tumors.				
		Ankle and Small Foot Joint Arthroscopy				

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