

**REHOBOTH MCKINLEY CHRISTIAN HOSPITAL
CLINICAL PRIVILEGES APPLICATION**

ORTHOPEDIC SURGERY

APPLICANT NAME: _____

CORE PRIVILEGES:

Orthopedic surgery privileges include admission, work up, diagnosis, and provision of nonsurgical and surgical care to patients of all ages to correct or treat various conditions, illnesses, and injuries of the musculoskeletal system, including provision of consultations. These core privileges do not include any of the privileges listed under Special Privileges. **These core privileges do not include any of the privileges listed under Special Privileges.**

NOTE: In the case of an emergency, to the degree permitted by license and regardless of department, staff status or clinical privileges, shall be permitted and shall be assisted by hospital personnel to do everything possible to save a patient from serious harm.

QUALIFICATIONS FOR CORE PRIVILEGES: (Check only the first one which applies to you)

CLASS IV:

___ **Completion of or certification in an Accreditation Council for Graduate Medical Education (ACGME)- or American Osteopathic Association (AOA)- approved subspecialty in Orthopedic Surgery.**

Subspecialty: _____

Members with these privileges are expected to be physicians with experience, training and competence of service as consultants and treating the most extreme illnesses including those within the subspecialty area.

CLASS III:

___ **Board certification in Orthopedic Surgery; or**
___ **Active board certification application in Orthopedic Surgery pending, having completed an ACGME- or AOA-approved post graduate training program in Orthopedic Surgery; or**
___ **Completion of an ACGME- or AOA-approved post graduate training program and full time orthopedic surgery experience for a minimum of the last five (5) years consecutively.**

Members with these privileges are expected to be physicians with experience, training and competence in their specialty. Such physicians would be expected to request consultation: (1) when hazardous treatment procedures are contemplated; (2) when unexpected complications arise; (3) or in cases in which treatment response seems unduly delayed.

Other training, please explain:

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ORTHOPEDIC SURGERY PRIVILEGES APPLICATION.

NAME: _____

SPECIAL PRIVILEGES: For each special request, you must state the training and number of procedures during training; or number of procedures performed in the last 12 months. If any one or all special privileges are not needed, YOU MUST CHECK "NO" UNDER "PRIVILEGES REQUESTED".

PRIVILEGES REQUESTED			
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>		
Complex hand surgery.			
Training/Experience: _____			
<input type="checkbox"/>	<input type="checkbox"/>		
Hemipelvectomy.			
Training/Experience: _____			
<input type="checkbox"/>	<input type="checkbox"/>		
Intravenous conscious sedation.			
Training/Experience: _____			
<u>NOTE: A PRACTITIONER GRANTED IV SEDATION PRIVILEGES MUST ADHERE TO PATIENT CARE SERVICES POLICY # 14.63.</u>			
<input type="checkbox"/>	<input type="checkbox"/>		
Laminectomy.			
Training/Experience: _____			
<input type="checkbox"/>	<input type="checkbox"/>		
Sports medicine.			
Training/Experience: _____			
<input type="checkbox"/>	<input type="checkbox"/>		
Use of surgical laser.			
Training/Experience: _____			
<input type="checkbox"/>	<input type="checkbox"/>		
Vascular grafts of the hands and forearm.			
Training/Experience: _____			
<u>ADDITIONAL PRIVILEGES (Specify, stated with training/experience):</u>			

APPLICANT SIGNATURE: _____

DATE: _____

ORTHOPEDIC SURGERY PRIVILEGES APPLICATION.

NAME: _____

DEPARTMENT REVIEW:

Comments/Recommendations/Suggestions:

Proctoring Arrangement: I have discussed the need for proctoring of this applicant. The following practitioner(s) who is/are member(s) of the Active Staff of the Medical Staff has/have been assigned:

Signed: _____
Department Chairperson

Date of Review

SURGERY DEPARTMENT.
Medical Staff Department

MSS: REVISED 09/99.