

CARLSBAD MEDICAL CENTER

ORTHOPEDICS APPLICATION FOR PRIVILEGES

NAME OF APPLICANT: _____

BOARD CERTIFICATION: _____ DATE: _____

Privileges in Orthopedic Surgery are granted for both clinical cognitive areas and specific procedures. All practitioners requesting Orthopedic Surgery privileges are to be board certified by the American Board of Orthopedic Surgery or by the American Osteopathic Board of Orthopedic Surgery, or must be fully trained in an accredited Orthopedic Surgery residency program recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

CHECK EACH AREA FOR WHICH YOU ARE REQUESTING PRIVILEGES:

R = Requested G = Granted D = Denied

GENERAL COGNITIVE PRIVILEGES

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Admitting and Attending Privileges |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assisting in Surgery Only |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consultation Only |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Critical Care Admission and Management |

PRIVILEGE LEVEL	PROCEDURAL PRIVILEGES
Level 1	USUAL AND CUSTOMARY ORTHOPEDIC SURGERY PROCEDURAL PRIVILEGES <ol style="list-style-type: none"> 1) These procedural privileges are usually and customarily performed by board certified, board eligible or fully trained Orthopedic Surgeons; and 2) Documentation of specific training and/or experience in Level 1 procedural privileges may be required; and 3) Level 1 procedural privileges are unasterisked.

PRIVILEGE LEVEL	PROCEDURAL PRIVILEGES
Level 2	ADVANCED ORTHOPEDIC SURGERY PROCEDURAL PRIVILEGES <ol style="list-style-type: none"> 1) These procedural privileges may be performed by board certified, board eligible or fully trained Orthopedic Surgeons; and 2) Level 2 procedural privileges require documentation of training and experience; and 3) Individual Level 2 procedural privileges must be proctored as defined on this privilege delineation form; and 4) Level 2 procedural privileges are denoted by * (one asterisk).

CARLSBAD MEDICAL CENTER –REQUEST FOR PRIVILEGES

Name of Applicant: _____

R = Requested G = Granted D = Denied

NOTE: If applying for an asterisked () privilege, enter the number and location of procedures performed in the last 2 years.*

R	G	D		# Performed	Location Performed
ANESTHESIA PROCEDURES					
CONSCIOUS SEDATION					
[]	[]	[]	Pediatric (<15 years) Moderate Sedation*	_____	_____
[]	[]	[]	Adult Moderate Sedation*	_____	_____
[]	[]	[]	Pediatric (<15 years) Deep Sedation*	_____	_____
[]	[]	[]	Adult Deep Sedation*	_____	_____
[]	[]	[]	Regional Anesthesia		

GENERAL PROCEDURES

[]	[]	[]	Carpal Tunnel Release		
[]	[]	[]	Amputations		
[]	[]	[]	Arthrocentesis		
[]	[]	[]	Arthrotomy		
[]	[]	[]	Biopsy, soft tissue and bone		
[]	[]	[]	Limb lengthening/shortening (non-amputation)*	_____	_____
FRACTURES					
[]	[]	[]	Open and closed, reduction with internal fixation/external fixation		
[]	[]	[]	Open and closed, reduction without internal fixation/external fixation		
GRAFTS					
[]	[]	[]	Split thickness		
[]	[]	[]	Full thickness*		
[]	[]	[]	Osteotomy, Osteotomy		
[]	[]	[]	Joint Aspiration		
[]	[]	[]	Joint Injection		
[]	[]	[]	Tendon Repair		
[]	[]	[]	Peripheral repair or reconstruction		
[]	[]	[]	Ligament repair or reconstruction		
[]	[]	[]	Fasciotomy		
[]	[]	[]	Bunionectomy		
[]	[]	[]	Hand surgery (except endoscopic carpal tunnel, see separate request)		

ARTHROSCOPIC PROCEDURES

[]	[]	[]	Shoulder
[]	[]	[]	Knee
[]	[]	[]	Ankle
[]	[]	[]	Elbow
[]	[]	[]	Wrist
[]	[]	[]	Hip

ENDOSCOPIC PROCEDURES

[]	[]	[]	Carpal Tunnel Release
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JOINT REPLACEMENT

PRIMARY			
[]	[]	[]	Knee
[]	[]	[]	Hip
[]	[]	[]	Shoulder
REVISION			
[]	[]	[]	

CARLSBAD MEDICAL CENTER –REQUEST FOR PRIVILEGES

Name of Applicant: _____

SPINE SURGERY

				#	
				Performed	Location Performed
			FUSION		
[]	[]	[]	Cervical (anterior and posterior)*	_____	_____
[]	[]	[]	Lumbar*	_____	_____
[]	[]	[]	Thoracic*	_____	_____
[]	[]	[]	Spinal Instrumentation*	_____	_____
			LAMINECTOMY—ALL		
[]	[]	[]	Cervical *	_____	_____
[]	[]	[]	Lumbar*	_____	_____
[]	[]	[]	Thoracic*	_____	_____
[]	[]	[]	Decompression*	_____	_____

OTHER PROCEDURES

[]	[]	[]	Specify: _____*	_____	_____
[]	[]	[]	Specify: _____*	_____	_____

I certify that I have had the necessary training and experience to perform the procedures that I have requested.

NAME OF APPLICANT (Please Print)

SIGNATURE

DATE

APPROVALS

All privilege delineations have been individually considered and have been recommended based upon the practitioner’s specialty, licensure, specific training, experience, health status, current competence and peer recommendations.

APPLICANT MAY PERFORM PRIVILEGES AND PROCEDURES AS INDICATED:

EXCEPTIONS/LIMITATIONS:

(specify)

Surgery Department Chairperson

Date

Medical Executive Committee

Date

Board of Trustees

Date

Name of Applicant: _____

ORTHOPEDIC SURGERY
CRITERIA FOR CLINICAL PRIVILEGES

Privileges followed by an asterisk (*) are identified in this table. Please submit required documentation when applicable at the time of appointment or reappointment. The numbers indicated in this table represent the minimal number of documented procedures required. Documentation must be submitted for consideration of the advanced privilege requested. Additional documentation of training, experience and/or current competence may be requested and additional proctoring may be requested at any time by the Department Chairperson, or the Medical Staff Executive Committee for any privilege requested.

PROCEDURES	TRAINING/EXPERIENCE	Number of Documented Procedures for Initial Appointment	Number of Procedures Every 2 Years	Number of Procedures to be Initially Proctored
ANESTHESIA				
Conscious Sedation – Pediatric (<15 years) Moderate Sedation or Analgesia	See Attachment C	2	1	N/A
Conscious Sedation – Adult Moderate Sedation or Analgesia	See Attachment C	2	1	N/A
Conscious Sedation – Pediatric (<15 years) Deep Sedation or Analgesia	See Attachment C	2	1	4
Conscious Sedation – Adult Deep Sedation or Analgesia	See Attachment C	2	1	4
GENERAL PROCEDURES				
Skin Graft, Full Thickness	Documentation of Successful Performance	2	1	1
Limb lengthening/shortening	Documentation of Successful Performance	2	1	1
SPINE SURGERY				
Fusion- Cervical	Documentation of Successful Performance	5	2	1
Fusion-Lumbar		5	2	1
Fusion-Thoracic		5	2	1
Disectomy	Documentation of Successful Performance	5	2	1
Spinal Instrumentation	Documentation of Successful Performance	5	2	1
Laminectomy -- Cervical	Documentation of Successful Performance	5	2	1
Laminectomy -- Lumbar		5	2	1
Laminectomy -- Thoracic		5	2	1

MEDICAL STAFF CREDENTIALING CRITERIA FOR CONSCIOUS SEDATION

Moderate Sedation or Analgesia

Separate privileges are granted for the categories of adult and pediatric (< 15 years) moderate sedation or analgesia, based on documentation of current competency.

All medical staff requesting any conscious sedation privilege must complete and document a review of the current medical staff conscious sedation policy. **In addition** to the required review of the conscious sedation policy, practitioners requesting privileges in conscious sedation must meet requirements of either #1 **or** #2 listed below:

1. Documentation of training, experience and current competence related to the use of moderate sedation or analgesia, **and** successful performance of at least (1) moderate sedation/analgesia case in the last (2) years for each category of moderate sedation or analgesia applied for and (2) sedation/analgesia cases at initial appointment **OR**
2. Documentation of relevant training and experience **AND**
 - a. Attendance at a Carlsbad Medical Center sponsored CME program on moderate sedation/analgesia **or** review of the videotape of such conference **and** achievement of a score of 85% or higher on the moderate sedation/analgesia post-test, **AND** provisional privileges will be granted pending outcome review.

Deep Sedation or Analgesia

Separate privileges to be granted for the categories of adult and pediatric (< 15 years) deep sedation or analgesia based on documentation of current competency. **All** medical staff requesting any conscious sedation privilege, must complete and document a review of the current medical staff conscious sedation policy **AND** maintain current ACLS certification (*PALS or NALS as appropriate*); **OR** be Board Certified or fully trained in a Carlsbad Medical Center approved residency training program in Emergency Medicine, Anesthesiology or Critical Care Medicine.

In addition to the required review of the conscious sedation policy, ACLS and board certification or residency requirements above, practitioners requesting privileges in conscious sedation must meet requirements of either #1 **or** #2 listed below:

1. Documentation of training, experience and current competence related to use of deep sedation/analgesia, **and** successful performance of at least (1) deep sedation/analgesia cases in the last (2) years for each category of deep sedation or analgesia applied for **OR**
2. Documentation of relevant training and experience, **AND ALL** of the following:
 - a. Attendance at a Carlsbad Medical Center-sponsored CME program on deep sedation/analgesia or review of the videotape of such conference and achievement of the score of 85% or higher on the deep sedation/analgesia post-test, **AND**
 - b. Provide documentation of successful completion of four (4) deep sedation/analgesia cases, in each category applied for, under the direct supervision of a Carlsbad Medical Center practitioner holding appropriate clinical privileges in deep sedation. If applying for both categories of deep sedation/analgesia, a total of six (6) cases will satisfy this requirement **AND**
 - c. Successful completion of four (4) intubations in the Operating Room under the direct supervision of a Carlsbad Medical Center credentialed anesthesiologist. If applying for both categories of deep sedation/analgesia, a total of six (6) cases will satisfy this requirement.



AUTHORIZATION FOR BACKGROUND CHECK

By signing below, I grant permission to the Hospital, its medical staff and representatives ("Hospital") to obtain an investigative report, to include state and federal criminal records and driving arrest records, for purposes of processing my medical staff application. I understand that I may request the Hospital to disclose the nature and scope of the investigation requested within five (5) days of my written request made within a reasonable time after the Hospital obtains the information. I also understand that I am entitled to request a summary of my rights with respect to consumer reporting agencies.

Print Name

Signature

Date