

**CARLSBAD MEDICAL CENTER  
PODIATRY  
APPLICATION FOR PRIVILEGES**

NAME OF APPLICANT: \_\_\_\_\_

BOARD CERTIFICATION: \_\_\_\_\_ DATE: \_\_\_\_\_

Privileges in Podiatry are granted for cognitive and procedural procedures. All practitioners requesting privileges in Podiatry are to have graduated from a fully accredited college of Podiatric Medicine, completed an accredited residency training program as defined in the level of procedures requested and/or be board certified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine or possess current competence and ability to perform the privileges requested as documented by knowledge and skills comparable to a trained or board certified podiatrist.

**COGNITIVE PRIVILEGES**

R = Requested	G = Granted	D = Denied	
<b>R</b>	<b>G</b>	<b>D</b>	
[ ]	[ ]	[ ]	Admitting and Attending Privileges
[ ]	[ ]	[ ]	Assisting in Surgery
[ ]	[ ]	[ ]	Consultation Only
[ ]	[ ]	[ ]	Podiatric History and Physical

PRIVILEGE LEVEL	PROCEDURAL PRIVILEGES
<b>LEVEL 1</b>	<p><b>USUAL AND CUSTOMARY PODIATRIC SURGERY PROCEDURAL PRIVILEGES</b></p> <p>1) These procedural privileges are usually and customarily performed by a podiatrist who has completed a:</p> <ul style="list-style-type: none"> <li>a. Rotating Podiatric Residency (RPR); OR</li> <li>b. Podiatry Orthopedic Residency ((POR); OR</li> <li>c. Podiatric Medical Residency (PGY 1 or Post graduate year); OR</li> <li>d. Can demonstrate current competence and ability to perform the privileges requested as documented by knowledge and skills comparable to a trained or board certified podiatrist in procedures requested; AND</li> </ul> <p>2) Level 1 procedural privileges in this category that are denoted by one (1) asterisk require documentation of training and experience and proctoring is required as defined on this privilege application form.</p>

**CARLSBAD MEDICAL CENTER –REQUEST FOR PRIVILEGES**

Name of Applicant: \_\_\_\_\_

<b>LEVEL 2</b>	<p><b>INTERMEDIATE PODIATRIC SURGERY PROCEDURAL PRIVILEGES</b></p> <p>1) These procedural privileges may be performed by podiatrists who:</p> <ul style="list-style-type: none"> <li>a. Have completed a two(2) year Podiatric Surgery Residency (PSR—24); OR</li> <li>b. Are board certified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine; OR</li> <li>c. can demonstrate current competence and ability to perform the privileges requested as documented by knowledge and skills comparable to a trained or board certified podiatrist in the procedures requested;</li> </ul> <p style="text-align: center;">AND</p> <p>2) Level 2 procedural privileges in this category that are denoted by one (1) asterisk require documentation of training and experience and proctoring is required as defined on this privilege application form.</p>
<b>LEVEL 3</b>	<p><b>ADVANCED PODIATRIC SURGERY PROCEDURAL PRIVILEGES (Reconstructive Rearfoot/Ankle Surgery)</b></p> <p>1) These procedural privileges may be performed by fully trained podiatrists who are board certified in reconstructive rearfoot/ankle surgery; AND</p> <p>2) Provide Malpractice Coverage for rearfoot/ankle surgery; AND</p> <p>3) Level 3 procedural privileges require documentation of training and experience, and/or can demonstrate continued and current competence in Level 4 procedural procedures; AND</p> <p style="text-align: center;">Individual Level 3 procedural privileges must be proctored as defined on this privilege application form</p> <p>4) All level 3 procedures are denoted by one(1) asterisks.</p>

**LEVEL 1: BASIC SURGERY**

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
			<b>ANESTHESIA</b>		
			<b>CONSCIOUS SEDATION</b>		
[ ]	[ ]	[ ]	Pediatric (<15 years) Moderate Sedation*	_____	_____
[ ]	[ ]	[ ]	Adult Moderate Sedation*	_____	_____
[ ]	[ ]	[ ]	Pediatric (<15 years) Deep Sedation*	_____	_____
[ ]	[ ]	[ ]	Adult Deep Sedation*	_____	_____
[ ]	[ ]	[ ]	Arthroplasty of lesser toes		
			<b>EXCISION OF</b>		
[ ]	[ ]	[ ]	Foreign body from digit		
[ ]	[ ]	[ ]	Soft Tissue tumor/mass of the foot		
[ ]	[ ]	[ ]	I & D of soft tissue infection		
[ ]	[ ]	[ ]	Nail Matrix/Matricectomy		
[ ]	[ ]	[ ]	Tenotomy and Capsulotomy of digit		
[ ]	[ ]	[ ]	Treatment of infections of the foot using systemic or parenteral antibiotics, incision and drainage.		

CARLSBAD MEDICAL CENTER –REQUEST FOR PRIVILEGES

Name of Applicant: \_\_\_\_\_

**LEVEL 2 : INTERMEDIATE PODIATRIC SURGERY PROCEDURES:**

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.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amputation		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Single digit*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple digits*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bunionectomy		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Without osteotomy or implantation		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	With Osteotomy*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Capsulotomy of mid or rearfoot		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Closed or open repair of fracture/dislocation of the Forefoot		
			Excision		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cutaneous Lesion of the Foot		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intermetatarsal neuromas		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metatarsal bones, complete/partial*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exostoses, forefoot		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osseous Tumors-- Forefoot		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Removal of foreign body from forefoot/rearfoot		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft Tissue lesion from forefoot/rearfoot (ganglion)		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fusion of the Metatarsal-Cuneiform Joint		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteotomy of phalanges, lesser digits		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plantar Fasciectomy /Fasciotomy		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis, implants, MPJ and IPJ in metatarsals		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sesamoidectomy (IPJ and MPF)		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Single Digit Resection		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin grafts to include pinch grafts of forefoot and rearfoot*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Syndactylism of toes		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendon transfer or redirection of forefoot*	_____	_____

**LEVEL 3: ADVANCED PODIATRIC SURGERY PROCEDURES:**

R	G	D		#Performed	Location Performed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Closed or Open Repair of Fracture/Dislocation of the Rearfoot*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mid-Tarsal Fusion*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple digit Resection*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osseous Tumors of the Rearfoot*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ostectomy of Tarsal Bones*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteotomies of Tarsal Bones*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Transfer/Rotation Flaps*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tarsal Tunnel Release*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendon Transfer or Redirection, Rearfoot*	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Surgery		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair of ligamentous structures of the ankle*	_____	_____

CARLSBAD MEDICAL CENTER -REQUEST FOR PRIVILEGES

Name of Applicant: \_\_\_\_\_

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



### **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.

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Print Name

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Signature

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Date