

(H) HEALTHSOUTH
 Delineation of Privileges - *Plastic Surgery*

Please indicate by a check in the requested column those privileges which are commensurate with your clinical ability, training and experience for which you are applying.

PRIVILEGES:	Requested	Not Requested	Approved	Denied
Evaluation and diagnosis of medical conditions to determine need for surgical intervention.				
Post-surgical evaluation and treatment:				
• Incision inspection				
• Staple/Stitch removal				
• Surgical site cleaning, packing/repacking				
• Medical management of post-surgical patients.				
• Management and insertion/removal of external drainage shunts.				

Your initials as used in Medical Records _____

Your signature as used in Medical Records _____

I, _____, hereby request privileges in the specialty of **Plastic Surgery** as indicated. I understand that privileges requested may differ from those approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

 Physician Date _____

APPROVAL:

Comments:

 Medical Director Date _____

 Governing Body Date _____