

Albuquerque Surgery Center  
1720 Wyoming NE  
Albuquerque, NM 87112

**Delineation of Privileges - General Surgery**

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

<b>PRIVILEGES:</b>	<b>Requested</b>	<b>Not Requested</b>	<b>Approved</b>	<b>Denied</b>
Amputation, please specify:				
Anal Surgery				
Appendectomy				
Breast biopsy				
Breast Prosthesis				
Bronchoscopy				
Carpal tunnel syndrome				
Colonoscopy				
Cyst/tumor excision				
Diagnostic Laparoscopy				
Esophagoscopy				
Evaluation and diagnosis of medical conditions to determine need for surgical intervention.				
Excision of pilonidal cyst				
Hernia repair <input type="checkbox"/> Femoral <input type="checkbox"/> Inguinal <input type="checkbox"/> Ventral <input type="checkbox"/> Epigastric				
I & D of abscess				
Interpret x-rays				
Laparoscopic appendectomy				
Laparoscopic cholecystectomy*				
Laparoscopic hernia repair				
Laparoscopy & lysis adhesions				
Laparoscopy with fundoplasty				
Laser type*:				
Ligation of perforators, subfacial				
Lymph node dissection and biopsy				
mastectomy				
Mastectomy, limited				
Muscle biopsy				
Partial thyroidlobectomy				
Peripheral nerve repair				
Placement and removal of venous access device				
Skin grafts with z-plasty				
Stereotactic Breast Bx Procedure*				
Temporal artery biopsy				
Tendon repair				
Thyroid surgery				
Thyroidectomy				
Vein ligation and stripping				
Wound drainage				

\*include documentation of continuing education/training.

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Your initials as used in Medical Records \_\_\_\_\_

Your signature as used in Medical Records \_\_\_\_\_

I, \_\_\_\_\_, hereby request privileges in the specialty of **General 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/President, Medical Staff	Date