

Albuquerque Surgery Center
1720 Wyoming NE
Albuquerque, NM 87112

Delineation of Privileges - Plastic 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.

PRIVILEGES:	Requested	Not Requested	Approved	Denied
Evaluation and diagnosis of medical conditions to determine need for surgical intervention				
Abdominoplasty				
Aesthetic and reconstructive procedures of the breast				
Augmentation mammoplasty				
Blepharoplasty – lower and upper				
Blepharoplasty – lower and upper				
Breast biopsy				
Browlift - coronal				
Cheek implants				
Chemical peel				
Chin augmentation				
Coronal lift				
Dermabrasion, face				
Destroy Lesions				
External ear surgery				
Facial resurfacing				
Gynecomastia				
Head and neck tumor surgery				
Hypospadias procedures				
Interpret x-rays				
Lacerations repair, simple and complex				
Liposuction surgery				
Mastopexy				
Maxillofacial surgery				
Neck Lift				
Otoplasty				
Palatoplasty and cheiloplasty				
Reduction mammoplasty				
Reimplantation extremities				
Removal of implants				
Rhinoplasty				
Scar revision, simple and complex				
Septoplasty				
Size reduction plastic operations				
Skin grafts – all types				
Tendon repair				
Hand Surgery				
Plastic operation of hand with tissue graft or prosthetic implant				
Reduction of fixation of fracture of the hand				
Suture of muscle, tendon and fascia of hand				
Transplantation of muscle tendon of hand				

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Do you anticipate giving local anesthesia? () Yes () No

Do you anticipate administering your own anesthesia? () Yes () No

Do you administer anesthesia at any other local facilities? () Yes () No

(* If yes, please complete Anesthesia Privileges for Non-Anesthesiologists.)

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/President, Medical Staff	Date