SSM ST. CLARE SURGICAL CENTER

CLINICAL PRIVILEGES IN PLASTIC AND RECONSTRUCTIVE SURGERY

 Initial ☐ **Renewed** ☐

Name ________________________ **Effective from** __/__/__ **to** __/__/__

Applicant: Please initial in the box in the R column for each privilege requested.

R = Requested G = Recommended As Requested C = Recommended with Conditions N = Not Recommended

Note: If Recommendations for clinical privileges are conditional, modified or are not recommended, the specific condition and its reason must be stated where indicated on the last page of this form.

R	G	C	N	Facial Fracture Repair & Immobilization
☐	☐	☐	☐	Mandibular Fractures: Closed Reduction and Inter-dental Wiring
☐	☐	☐	☐	Mandibular Fractures: Open Reduction, With or Without Inter-dental Wiring
☐	☐	☐	☐	Maxillary Fracture: Closed Reduction and Inter-dental Wiring
☐	☐	☐	☐	Maxillary Fracture: Open Reduction With or Without Inter-dental Wiring
☐	☐	☐	☐	Orbital Floor or Rim Fracture: Closed Reduction
☐	☐	☐	☐	Orbital Floor or Rim Fracture: Open Reduction and/or Fixation or Graft

R	G	C	N	Hand Surgery
☐	☐	☐	☐	Arthrodesis
☐	☐	☐	☐	Arthroplasty With or Without Prosthesis
☐	☐	☐	☐	Fingertip Injuries
☐	☐	☐	☐	Fractures
☐	☐	☐	☐	Local Flaps or Grafts
☐	☐	☐	☐	Neurolysis
☐	☐	☐	☐	Osteotomy
☐	☐	☐	☐	Primary or Secondary Nerve Repair
☐	☐	☐	☐	Primary or Secondary Tendon Repair

R	G	C	N	Facial Reconstruction Surgery
☐	☐	☐	☐	Blepharoplasty
☐	☐	☐	☐	Brow Lift

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R	G	C	N	Facial Reconstruction Surgery
☐	☐	☐	☐	Chemical Peel or Dermabrasion
☐	☐	☐	☐	Chin Implant
☐	☐	☐	☐	Complete Nasal Reconstruction
☐	☐	☐	☐	Face Lift (Rhytidectomy)
☐	☐	☐	☐	Nasal Reconstruction
☐	☐	☐	☐	Malar Implant
☐	☐	☐	☐	Otoplasty
☐	☐	☐	☐	Rhinoplasty
☐	☐	☐	☐	Septoplasty or Septectomy

R	G	C	N	Breast Reconstruction Surgery
☐	☐	☐	☐	Augmentation Mammoplasty
☐	☐	☐	☐	Breast Biopsy
☐	☐	☐	☐	Mastopexy
☐	☐	☐	☐	Insertion of Tissue Expander
☐	☐	☐	☐	Reduction Mammoplasty
☐	☐	☐	☐	Release of Capsular Construction after Augmentation Mammoplasty

R	G	C	N	Body Contouring
☐	☐	☐	☐	Liposuction Procedures

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Applicant: Please initial in the box in the R column for each privilege requested.

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R	G	C	N	**Benign and Malignant Tumors**
☐	☐	☐	☐	Soft Tissue Tumor Excision: Neurofibroma
☐	☐	☐	☐	Soft Tissue Tumor Excision: Pigmented Nevi
☐	☐	☐	☐	Soft Tissue Tumor Excision: Cysts
☐	☐	☐	☐	Soft Tissue Tumor Excision: Lipomata

R	G	C	N	**Other**
☐	☐	☐	☐	Excision of Lesion
☐	☐	☐	☐	Skin Grafts

R	G	C	N	**Special Procedures/Techniques**
☐	☐	☐	☐	CO2 Laser
☐	☐	☐	☐	Use of Laser Indicate the Types of Laser Equipment/Type of Laser Procedures you would like to use/perform at the Surgery Center:

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Name ______________________ **Effective from** ___/___/___ **to** ___/___/___

I have requested only those specific privileges for which my education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at ***SSM St. Clare Surgical Center***. I request privileges for the above procedure(s) with the understanding that I consider myself to be in good physical and mental health and I am capable of providing quality care that is acceptable to ***SSM St. Clare Surgical Center***.

I verify/confirm that I have am currently privileged to perform the same procedures that I am requesting, above, at a local, Joint Commission Accredited, State licensed, and Medicare approved hospital.

______________________ ______________________ ______________

Practitioner Signature   Practitioner Name: Type or Print   Date

Approved by the Credential/Medical Advisory Committee of the Medical Staff and duly appointed to the Medical Staff by the Governing Board.

______________________ ______________

Medical Director Approval   Date

______________________ ______________

Governing Board   Date

If Recommendations for clinical privileges are conditional, modified or are not recommended, the specific condition and reason(s) must be stated on this last page and practitioner notified in writing within three days by Administrator and Medical Director.