

CLINICAL PRIVILEGES IN SPINE SURGERY

Page 1 of 3

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 General Spine Privileges

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Biopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nerve Biopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sural Biopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumbar Puncture |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Carpal Tunnel Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Removal of Superficial Scalp Lesions |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Resection of peripheral nerve tumors |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neck Spine Fusion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Microdiscectomy (Hemi-laminectomy) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neck Spine Disk Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cervical Spine Arthrodesis- Anterior |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cervical Spine Arthrodesis-Posterior |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cervical Spine Discectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoracolumbar Spine Arthrodesis-Posterior |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoracolumbar Spine Arthrodesis-Anterior |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoracolumbar Spine |

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Page 2 of 3

Initial

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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 Spine Privileges

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumbar Discectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumbar Laminectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Illiic Crest Bone Graft |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cervical Instrumentation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumbar Instrumentation |

R G C N Other

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IV/Conscious Sedation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | X-Ray Interpretation: C-ARM |

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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.