

Heart Hospital of New Mexico  
Surgery Department  
**Podiatry**

Delineation of Core Privileges

**A) ELIGIBILITY CRITERIA:**

Medical Education:

- DPM

Minimum Formal Training:

- A rotating podiatric residency;
- OR**
- A podiatric orthopedic residency;
- OR**
- A 12-month podiatric surgical residency approved by the Council on Podiatry Education

**OR**

Experience:

Applicants must demonstrate that they have performed in the past two (2) years at least 30 Class I procedures and at least 20 Class II procedures.

**AND**

Board Certification:

- Certified by the American Board of Podiatric Surgery

Clinical References:

- As outlined in the Procedure for Appointment, Reappointment and Clinical Privileges of the Medical Staff of the Heart Hospital of New Mexico

- B) RECREDENTIALING CRITERIA:** Physicians must perform at least 20 procedures of satisfactory quality over the previous two (2) year time period at any accredited hospital. Failure to meet the recredentialing criteria will require appeal to the Medical Executive Committee.

Heart Hospital of New Mexico  
**PODIATRY**  
Core I Privileges

Performance of Podiatry procedures to correct or treat various conditions, illnesses and injuries related to Podiatry.

A representative, but of necessity not complete list of Podiatric procedures is stated below. It is assumed that other procedures and problems of similar complexity will fall within the identified PODIATRY privileges.

Class I – Toenails and Skin Care:

- Care of toenails and skin lesions of the foot at bedside.
- Surgical assisting privileges.

Class II – Forefoot and Simple Rear Foot Procedures:

- Hallux Valgus repair
- Tarsometatarsal fusions
- Metatarsal osteotomies
- Excision of soft tissue neoplasms of the foot
- Tenolysis of the forefoot
- Plantar fasciotomy, open and endoscopic
- Osteotomies of the midfoot and rear foot ie: heel spurs and Haglund's deformities
- Amputation of the digitis
- Metatarsal amputation
- Arthroplasties of the forefoot
- I&D, foot abscess and excision of the forefoot
- Sinus tarsi soft tissue decompression
- Excision of accessory oscicles, midfoot and forefoot
- Open and closed reduction of tarsal/metatarsal fractures, dislocations, does not include Talus or calcaneus
- Repair of soft tissue trauma, foot
- Excision, soft tissue tumors, foot
- Repair soft tissue trauma, foot
- Excision of foreign body, foot

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Core Privilege Request Form

Having reviewed the requirements for each set of privileges, I would request the following privileges:

*Place a check mark in the appropriate box for each set of privileges. Cross out any procedures not currently performed in your clinical practice.*

Privilege	Procedures	Requested	Not Requested
<b>CORE I PRIVILEGES</b>			
	<p><u>Class I – Toenails and Skin Care:</u></p> <ul style="list-style-type: none"> <li>▪ Care of toenails and skin lesions of the foot at bedside.</li> <li>▪ Surgical assisting privileges.</li> </ul> <p><u>Class II – Forefoot and Simple Rear Foot Procedures:</u></p> <ul style="list-style-type: none"> <li>▪ Hallux Valgus repair</li> <li>▪ Tarsometatarsal fusions</li> <li>▪ Metatarsal osteotomies</li> <li>▪ Excision of soft tissue neoplasms of the foot</li> <li>▪ Tenolysis of the forefoot</li> <li>▪ Plantar fasciotomy, open and endoscopic</li> <li>▪ Osteotomies of the midfoot and rear foot ie: heel spurs and Haglund’s deformities</li> <li>▪ Amputation of the digitis</li> <li>▪ Metatarsal amputation</li> <li>▪ Arthroplasties of the forefoot</li> <li>▪ I&amp;D, foot abscess and excision of the forefoot</li> <li>▪ Sinus tarsi soft tissue decompression</li> <li>▪ Excision of accessory oscicles, midfoot and forefoot</li> <li>▪ Open and closed reduction of tarsal/metatarsal fractures, dislocations, does not include Talus or calcaneus</li> <li>▪ Repair of soft tissue trauma, foot</li> <li>▪ Excision, soft tissue tumors, foot</li> <li>▪ Repair soft tissue trauma, foot</li> <li>▪ Excision of foreign body, foot</li> </ul>		
<b>MODERATE SEDATION</b> <i>(complete separate form)</i>			
<b>RESTRAINT PRIVILEGES</b>			

**I attest by signature that I have met the minimum criteria of procedures/diagnoses management within my clinical practice for the procedures requested above, and I agree to provide documentation of said procedures/diagnoses management if requested.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**The Department Chairperson accepts this applicant's attestation that he/she meets the minimum criteria for privileges requested.**

\_\_\_ Yes \_\_\_ No \_\_\_\_\_  
Department Chair Signature

\_\_\_\_\_  
Date