

# ARTESIA GENERAL HOSPITAL

NAME: \_\_\_\_\_

Privilege Request: **PODIATRY** -

**PRIVILEGES WILL BE GRANTED ON AN INDIVIDUAL BASIS, BASED ON DOCUMENTED EXPERIENCE, TRAINING AND DEMONSTRATED COMPETENCE. ANY CHANGES OR EXCEPTIONS ARE SUBJECT TO REVIEW AND APPROVAL BY THE APPROPRIATE COMMITTEES OF THE MEDICAL STAFF.**

PRIV. REQ.	PRIV. GRANTED	CATEGORY A: GENERALLY ENCOMPASSES DIGITAL SURGERY OF ALL TYPES	PRIV. REQ.	PRIV. GRANTED	CATEGORY B: GENERALLY ENCOMPASSES ALL FOREFOOT SURGERY
( )	( )	Nails - partial and complete excision, includes matrices	( )	( )	Excision of soft tissue tumors of forefoot - e.g. intermetatarsal neuroma, ganglion, etc.
( )	( )	Excision benign lesion of soft tissue - superficial only - does not include ganglionic cysts or others of similar magnitude	( )	( )	Bursectomies, forefoot only
( )	( )	Bunionectomies - digits	( )	( )	Incision and drainage deep complicated soft tissue abscess
( )	( )	Repair simple lacerations of foot and digital trauma except digital fractures	( )	( )	All digital tendon incisions, excisions, lengthenings, shortenings and transpositions including extensor hallucis longus
( )	( )	Excision and repair of nerves and lesions of digits	( )	( )	Repair uncomplicated soft tissue trauma, forefoot only
( )	( )	Incision and drainage superficial uncomplicated abscess with insertion of drain	( )	( )	Excision of foreign body, forefoot only
( )	( )	Tenotomies, tendon lengthenings and tendon repair digital tendons except extensor hallucis longus	( )	( )	Open and closed reductions of hallux and metatarsal fractures
( )	( )	Interphalangeal joint and metatarsal-phalangeal joint capsulotomies	( )	( )	Partial osteotomies, metatarsals including dorsal metatarsal-cuneiform exostoses
( )	( )	Pharyngeal arthrotomies	( )	( )	Excision accessory bones, forefoot only
( )	( )	Interphalangeal arthroplasties	( )	( )	Arthroplasties metatarsal-phalangeal joints
( )	( )	Partial and total phalangectomies	( )	( )	Arthrodeses interphalangeal and metatarsal-phalangeal joints
( )	( )	open and closed reduction phalangeal fractures except hallux	( )	( )	Osteotomies, hallux and metatarsals
( )	( )	Phalangeal osteotomies except hallux	( )	( )	Simple bunionectomies
( )	( )	Intra or interphalangeal amputations	( )	( )	Radial hallux valgus and varus operations except Lapidus-type procedures and implant arthroplasty procedures
			( )	( )	Amputation of toes (metatarsal-phalangeal joint disarticulation)

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<b>PRIV. REQ.</b>	<b>PRIV. GRANTED</b>	<b>CATEGORY C: GENERALLY INCLUDES OTHER COMMON BUT MORE DIFFICULT TYPES OF SURGERY OF THE FOREFOOT AND REARFOOT</b>	<b>PRIV. REQ.</b>	<b>PRIV. GRANTED</b>	<b>CATEGORY D: GENERALLY INCLUDES THE DIFFICULT AND LESS COMMON TYPES OF SURGICAL RECONSTRUCTION OF THE FOOT AND ANKLE. THIS CATEGORY ALSO INCLUDES TREATMENT OF EXTENSIVE MULTIPLE PROCEDURE COMBINATIONS WHERE THE SPEED AND SKILL REQUIRED OF THE SURGEON IS FAR GREATER THAN WHEN THE SAME PROCEDURES ARE STAGED ON LESSER NUMBERS AT ONE SURGICAL INTERVAL.</b>
( ) ( )		Excision of deep soft tissue tumors rearfoot and ankle - e.g. neuroma, ganglion, lipoma, muscle biopsy, etc.			
( ) ( )		Repair all soft tissue trauma foot and ankle			
( ) ( )		Excision of foreign body rearfoot and ankle			
( ) ( )		Simple plastic surgical procedures of foot and ankle including nonextensive skin grafting	( ) ( )		Complicated plastic surgical procedures of foot and ankle, including extensive skin grafting
( ) ( )		Decompression of nerve entrapment (neurolysis) foot and ankle	( ) ( )		Major tendon surgery of foot and ankle such as tendon transpositionings, recessions, suspensions
( ) ( )		Tendo Achilles lengthening	( ) ( )		Ankle stabilization procedures
( ) ( )		Peroneal tendon lengthening	( ) ( )		Open and closed reduction fractures of talus, calcaneus ankle
( ) ( )		Incision, excision, lengthening and shortening of fascia, including plantar fibromatosis	( ) ( )		Arthroplasties, with or without implants, tarsal and ankle joints e.g. subtalar joint implant arthroereisis
( ) ( )		Excision of accessory bones, rearfoot	( ) ( )		Arthrodesis tarsal and ankle joints
( ) ( )		All forefoot implant arthroplasties	( ) ( )		Osteotomy, multiple tarsal bones - e.g. tarsal wedge osteotomy
( ) ( )		Partial ostectomy tarsal bones - e.g. Haglund's plantar heel spur, navicular tuberosity, tarsal coalitions, etc.	( ) ( )		Osteotomy, tibia and fibula
( ) ( )		Open and closed reduction mid-tarsal fractures - does not include talus, calcaneus	( ) ( )		Surgical treatment of osteomyelitis of rearfoot and ankle
( ) ( )		Osteotomy, single, tarsal bone - e.g. Dwyer osteotomy of calcaneus	( ) ( )		Amputations - all others within the foot
( ) ( )		Arthrodesis of metatarsal-tarsal joints			
( ) ( )		Total forefoot reconstructive procedures - e.g. Hoffman, Hibbs, Heyman-Herndon-Strong, etc.			
( ) ( )		Ray amputations			
( ) ( )		Surgical treatment of osteomyelitis of forefoot			

**PLEASE COMPLETE THE FOLLOWING:**

- 1) Current unrestricted New Mexico License Number \_\_\_\_\_.
- 2) Current DEA Number \_\_\_\_\_.
- 3) Do you have any physical or mental disabilities that would interfere with your performance of the privileges requested? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_ If YES, please attach a written explanation.
- 4) Fellowship in the American College of \_\_\_\_\_  
\_\_\_\_\_.
- 5) Certified by \_\_\_\_\_ or eligible \_\_\_\_\_ for American Board of \_\_\_\_\_.
- 6) Certified by Subspecialty Board \_\_\_\_\_.
- 7) Other certification \_\_\_\_\_.
- 8) Have your Medical Staff privileges at any hospital been modified in the past other than upon your request? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_ If YES, please attach a written explanation.

**APPLICANT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE -- FOR COMMITTEE USE ONLY**

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**RECOMMENDED**

**NOT RECOMMENDED**

**Chairman, Credential Committee** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Chairman, Executive Committee** \_\_\_\_\_ **Date:** \_\_\_\_\_

**APPROVED:**

**Chairman, Board of Trustees** \_\_\_\_\_ **Date:** \_\_\_\_\_



## CONFIDENTIALITY STATEMENT

I, \_\_\_\_\_, understand that in performance of my duties at Artesia General Hospital, I am required to have access to and am involved in the processing of patient care data. I understand that I am obligated to maintain the confidentiality of these data at all times, both at work and off duty. I understand that a violation of these confidentiality considerations may result in disciplinary action, including termination. I further understand that I could be subject to legal action. I agree to comply with information security policies for Artesia General Hospital concerning the privacy and confidentiality consideration of patient care.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**MEDICAL STAFF SIGNATURE AUTHENTICATION FORM**

Medicare regulation 482.24, authentication of signature, requires that the medical records department maintain a current list of authenticated signature, written initials, codes and stamps, when such are used for authorship.

\_\_\_\_\_  
**Physician Name and Title (PRINTED)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Initials

**Approved Signature Stamps or Seals:**

Original: Credential File  
CC: Pharmacy, Medical Records



**PHYSICIAN'S ACKNOWLEDGEMENT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) requires hospitals to obtain a signed ***Physician's Acknowledgement Statement*** from any physician who is being granted admitting privileges at that Hospital.

Your signature acknowledges that you have received the following notice [42 CFR 41246 (b)]:

*Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnosis, and the major procedure performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.*

\_\_\_\_\_  
**Physician Name and Title (PRINTED)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
UPIN/NPI #



**BYLAWS ACKNOWLEDGEMENT OF RECEIPT**

I, \_\_\_\_\_, acknowledge that I have read and understood the Medical Staff Bylaws, Rules and Regulations of Artesia General Hospital.

Furthermore, I agree to abide by all such Bylaws, Rules and Regulations, Hospital Policies and Directives during the time I remain appointed to the Medical Staff or Allied Health Professional Staff of Artesia General Hospital.

\_\_\_\_\_  
**Physician Name and Title (PRINTED)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature