

NOR-LEA GENERAL HOSPITAL

PRIVILEGE REQUEST

Podiatry

NAME: _____ DATE: _____

This request for privileges must be completed for initial appointment or for periodic re-appointment to the Medical Staff of NOR-LEA GENERAL HOSPITAL. The listing of privileges for which recognition is required is not all inclusive and may be changed from time to time through addition or deletion. Privileges not listed that you wish to have considered may be listed in the section titled "Other". Your request will be evaluated by the Medical Staff in accordance with the Bylaws and you will be notified of their recommendations if they are different from your request.

In addition to assigned privileges, emergency privileges provide that any member of the Medical Staff shall be permitted and assisted in emergency care necessary to save the life, limb or organ of a patient. (Refer to Emergency Privileges in the Bylaws.)

I AM QUALIFIED FOR AND REQUEST THE FOLLOWING PRIVILEGES:

Class I Podiatry Privileges:

_____ Care of nails, calluses, corns, benign skin lesions and mechanical treatment of the foot.

Class II Podiatry Surgical Privileges:

_____ Excision benign neoplastic, cicatricial, inflammatory or congenital lesions of soft tissue.

_____ Incision & removal of foreign bodies

_____ Bursectomies

_____ Excision lesions & repair digital nerves.

_____ Repair lacerations & trauma of the foot.

_____ Ostectomies: phalanges, metatarsals.

_____ Excision calcaneal spur (plantar or posterior)

_____ Open & closed reduction phalangeal & metatarsal fractures

_____ Arthroplasties phalangeal & metatarsal joints

_____ Arthrodeses, phalanges & metatarsals

_____ Osteotomies, phalanges & metatarsals

_____ Excision accessory bones except as trigonum

_____ Phalangeal arthrotomies

_____ Interphalangeal arthroplasties

_____ Partial & total phalangectomies

____ Simple bunionectomies

____ Hallux valgus & varus operations

____ Tendon incision, excisions. Repair lengthening, shortening & transplantation of all tendons except tendon Achillis

____ Excision, lengthening & shortening of fascia.

OTHER

Date _____ Signature _____

Approved by Medical Staff:

Chief of Staff

Date

Approved by Board of Trustees

Board of Trustees

Date