

**WEST JEFFERSON MEDICAL CENTER**  
**Marrero, Louisiana**  
**PRIVILEGE REQUEST FORM FOR GENERAL SURGERY**

**Minimum Threshold Criteria**

*To be eligible to use this form to request clinical privileges, the following minimum threshold criteria must be met.*

1. *Basic education:* M.D. or D.O.;
2. *Training:* Successful completion of a postgraduate residency program in general surgery approved by the Accrediting Council for Graduate Medical Education or its equivalent; and
3. *Experience:* The applicant's ability to demonstrate that he or she has performed at least 100 general surgical procedures during the past 24 months.

*If you meet the criteria above, you may request privileges as specified below. Any special requests will be considered only if the minimum threshold criteria are met for each request.*

**Core Privileges**

*I hereby request core general surgical privileges as follows:*

1. The performance of surgical procedures (including related admission, consultation, workup, pre- and postoperative care) to correct or treat various conditions, illnesses, and injuries of the:
  - \*alimentary tract;
  - \*abdomen and its contents;
  - \*breasts, skin, and soft tissue;
  - \*head and neck;
  - \*vascular system-limited to the following: emergent post-traumatic vascular injury, and vascular shunts for dialysis
  - \*endocrine system; and
  - \*minor extremity surgery (i.e., biopsy, I&D, varicose veins, foreign body removal, skin grafts, and dialysis shunt).
2. The comprehensive management of trauma, including:
  - \*musculoskeletal, hand, and head injuries; and
  - \*the complete care of critically ill patients with underlying surgical conditions in the emergency department, intensive care unit, and the trauma/burn units.

**Special Requests**

*I hereby request the following special privileges:*

- Laser surgery
- Laparoscopic surgery
- Gastroscopy
- Swan-Ganz
- Bronchoscopy
- Endoscopy
- Stereotactic breast biopsy

*I understand that in making this request, I am bound by West Jefferson Medical Center's applicable bylaws and policies. I hereby stipulate that I meet the threshold criteria for each request.*

Physician's signature

\_\_\_\_\_  
Typed or Printed Name

\_\_\_\_\_  
Date

Approved: 1/97

Revised: 11/01

**In general, core privileges consist of those areas listed above. The medical staff may modify or limit the privileges granted.**