APPLICANT NAME: ____________________

ORTHOPEDICS SURGERY

I hereby request surgical privileges in the specialty of Orthopedics as shown in this form. I understand that privileges granted are subject to a bi-annual review coinciding with reapplication for medical staff membership. I also understand that application for additional or new procedures can be made at any time with proper documentation.

Please indicate with an "X" in the appropriate box and by signature at the end of this document the procedures you are requesting privileges for.

Applied for	Approval	
☐ Amputations of disarticulations of digits	☐ YES	☐ NO
☐ Application of plaster or synthetic splints and casts	☐ YES	☐ NO
☐ Arthoroscopic surgery	☐ YES	☐ NO
☐ Arthrodesis- various joints	☐ YES	☐ NO
☐ Arthrography of various joints	☐ YES	☐ NO
☐ Aspiration and/or injection of joints, bursae, cysts- local anesthetics, cortisone derivatives, etc.	☐ YES	☐ NO
☐ Biopsy, bone or soft tissue- incisional or needle	☐ YES	☐ NO
☐ Bone drilling operation	☐ YES	☐ NO
☐ Bone grafting procedures for various indications	☐ YES	☐ NO
☐ Closed or open reduction of fractures and dislocations of the extremities	☐ YES	☐ NO
☐ Debridements or repair of wounds of head, neck and extremities	☐ YES	☐ NO
☐ Decompression of nerve, tendon, or soft tissue	☐ YES	☐ NO
☐ Diagnostic arthroscopy	☐ YES	☐ NO
☐ Epiphyseal arrest or stimulation	☐ YES	☐ NO
☐ Excision of bursae, ganglions, or cyst	☐ YES	☐ NO
☐ Excision of tumors, calcium deposits neuromas, or other masses from soft tissue and bone of extremities	☐ YES	☐ NO
☐ Fasciotomy and fascietomy	☐ YES	☐ NO
☐ Incision, drainage, and closed irrigation acute or chronic infectious processes in extremities	☐ YES	☐ NO
☐ Insertion of external skeletal fixation and traction devices (Steinman Pins, Hoffman, Halo, etc.)	☐ YES	☐ NO
☐ Internal fixation of fractures of the extremities	☐ YES	☐ NO
☐ Local skin flaps	☐ YES	☐ NO
☐ Ostectomy- partial or complete (i.e.: distal ulna, carpal or tarsal bones)	☐ YES	☐ NO
☐ Ostetomies various bones- correction of deformity, shortening, lengthening, etc.	☐ YES	☐ NO
☐ Partial or total replacement arthroplasties such as fingers, toes	☐ YES	☐ NO

Procedure		
❑ Realignment procedure of foot or hand (i.e.: bunionectomies, pollicization, etc.)	❑ YES	❑ NO
❑ Reconstruction of ligaments and joint stabilization procedures	❑ YES	❑ NO
❑ Reconstructive arthroplasty- various joints of extremities	❑ YES	❑ NO
❑ Removal of foreign or loss bodies in extremities, back, and neck	❑ YES	❑ NO
❑ Repair of acute or old ruptures of ligaments	❑ YES	❑ NO
❑ Repair of acute or recurrent capsular joint injuries (i.e.: Bankart, AC joint repair)	❑ YES	❑ NO
❑ Repair of non-union of bone with reduction, fixation, grafting electrical stimulation, etc.	❑ YES	❑ NO
❑ Repair, transplant, or lysis of peripheral nerve	❑ YES	❑ NO
❑ Skin grafts and tunnel procedures of extremities	❑ YES	❑ NO
❑ Synovectomy of various joints	❑ YES	❑ NO
❑ Tendon fixation, suture, transplant, or transfer	❑ YES	❑ NO
❑ Radiography Use of Modality & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Ultrasound Use of Modality & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Fluoroscopy Use of Modality with State License & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Local anesthesia	❑ YES	❑ NO
❑ Conscious Sedation	❑ YES	❑ NO
❑ Supervision of Conscious Sedation Trained Registered Nurse	❑ YES	❑ NO
OTHERS NOT LISTED		
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

Signature of Applicant ________________ Date ________________

Signature of QI Committee Chairperson ________________ Date ________________

Signature of Governing Body Chairperson ________________ Date ________________