PODIATRY SURGERY

I hereby request surgical privileges in the specialty of Podiatry as shown on 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 and executive leadership approval of the board of directors.

I wish to be considered for the following procedures, of which I have ample training both in post-graduate surgical rotations and through proctoring with other highly skilled individuals.

My "X" in the appropriate box to the left of the procedure denotes my level of interest in being able to perform this procedure at your facility.

________________________________ **Printed Name**

Applied for	Approved	
❑ Superficial skin lesion of the foot	❑ YES	❑ NO
❑ Subcutaneous skin lesion, ganglion, bursa, lipoma, others pertaining to the foot	❑ YES	❑ NO
❑ Tenotomy, capsulotomy of the foot	❑ YES	❑ NO
❑ Intermetatarsal neuronectomy	❑ YES	❑ NO
❑ Partial or complete toenail avulsion with/without matrixectomy	❑ YES	❑ NO
❑ Subungual exostectomy of the foot	❑ YES	❑ NO
❑ Lesser digital, partial osteotomy, exostectomy, etc. of the foot	❑ YES	❑ NO
❑ Hallux, partial osteotomy or exostectomy – condylectomy or supernumerary bones	❑ YES	❑ NO
❑ Open reduction – digit fracture of the foot	❑ YES	❑ NO
❑ Excision of plantar fibromatosis	❑ YES	❑ NO
❑ Lesser metatarsal head resection, partial/complete buionette	❑ YES	❑ NO
❑ Osteotomy of lesser metatarsals with internal fixation	❑ YES	❑ NO
❑ Osteotomy of lesser metatarsal head/neck with/without internal fixation	❑ YES	❑ NO
❑ Bunionectomy, Silver	❑ YES	❑ NO
❑ Bunionectomy, Keller	❑ YES	❑ NO
❑ Bunionectomy, McBride with/without sesamoidectomy	❑ YES	❑ NO
❑ Bunionectomy, Keller with implant	❑ YES	❑ NO
❑ Bunionectomy, Akin	❑ YES	❑ NO
❑ Bunionectomy, modified Mayo or Stone	❑ YES	❑ NO
❑ Bunionectomy, aductus osteotomy with internal fixation	❑ YES	❑ NO
❑ Bunionectomy, Austin horizontal V osteotomy	❑ YES	❑ NO
❑ Sesamoidectomy	❑ YES	❑ NO
❑ Dorsal cuneiform exostectomy	❑ YES	❑ NO

❑ **Plantar calcaneal exostectomy and/or plantar facial release**	❑ **YES**	❑ **NO**
❑ **Open reduction – metatarsal fracture**	❑ **YES**	❑ **NO**
❑ **Digital arthrodesis**	❑ **YES**	❑ **NO**
❑ **Syndactylism**	❑ **YES**	❑ **NO**
❑ **Forefoot tendon transfer**	❑ **YES**	❑ **NO**
❑ **Retrocalcaneal exostosis**	❑ **YES**	❑ **NO**
❑ **Repair navicular tuberosity or accessory navicularis without tendon transfer**	❑ **YES**	❑ **NO**
❑ **Total replacement of first metatarsal phalangeal joint**	❑ **YES**	❑ **NO**
❑ **Total forefoot joint replacement of lesser M.P. or I.P. joint**	❑ **YES**	❑ **NO**
❑ **Repair navicular tuberosity or accessory navicularis with tendon transfer**	❑ **YES**	❑ **NO**
❑ **Tarsal tunnel release**	❑ **YES**	❑ **NO**
❑ **Pan matatarsectomy**	❑ **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**
If the use of a laser or other laser-like equipment is necessary, then list below the		
type of laser requested for the procedure and the procedures you plan to do with		
laser.____		
____		

APPLIED FOR	APPROVAL	
❑ infection, Lacerations, Foreign Bodies, Scars, Tumor, Tendon, Ligament Graft, Flap,	❑ YES	❑ NO
❑ Nerve Fasciotomies,	❑ YES	❑ NO
❑ Bursectomy, Syndactylism	❑ YES	❑ NO
❑ Toenail Surgery	❑ YES	❑ NO
❑ Soft Tissue Procedures Ankle	❑ YES	❑ NO
❑ Fractures and Dislocations Foot, including	❑ YES	❑ NO
❑ Repair of Non-Union/Mal-Unions of Fractures	❑ YES	❑ NO
❑ Fractures and Dislocations Ankle, including Repair of Non-Unions/Mal-Unions of Fractures	❑ YES	❑ NO
❑ Correction of Bone, Joint Deformities,	❑ YES	❑ NO
❑ Foot Osteotomies, exostosis, accessory bones, arthroplasty, arthrodesis, implants.	❑ YES	❑ NO
❑ Correction of Bone, Joint Deformities, Ankle.[X] H. Arthroscopy Joints, Foot and Ankle.	❑ YES	❑ NO
❑ Bone Procedures Foot -Infection, Tumor, Cyst, Necrotic Bone and Tissue, Toe Amputations,	❑ YES	❑ NO
❑ Amputation through foot	❑ YES	❑ NO
❑ Bone Procedures Ankle	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
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	❑ YES	❑ NO
	❑ YES	❑ NO
	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

As the applicant, you are attesting to the fact of the matter that your training in school, residency, fellowships, proctor, supervisions by others that are highly trained and skilled have given you the skills and experience to perform the cases above. You also understand that it is the applicants' responsibility to ensure that a copy of your procedures from your training (whether it be a hospital or another surgery center) is required to prove the level of experience you declare.

______________________________	______________________
Signature of Applicant	**Date**
______________________________	______________________
Signature of Medical Staff Officer/Director	**Date recommended**
______________________________	______________________
Signature of Governing Body chairperson	**Date recommended**