APPLICANT NAME:_____

PLASTIC SURGERY

I hereby request surgical privileges in the specialty of Plastic Surgery 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.

Documentation of training and experience is attached for those procedures marked by an asterisk (*) and those procedures that are outside of your original specialty training.

Applied for	**Approved**	
HEAD & NECK SURGERY		
❑ Plastic repair of mouth and lip	❑ YES	❑ NO
❑ Reconstruction of soft tissues of face, head and Neck	❑ YES	❑ NO
EYE SURGERY		
❑ Blepharoplasty	❑ YES	❑ NO
❑ Dilatation or repair of lacrimal eyelid	❑ YES	❑ NO
❑ Plastic repair of eyelid	❑ YES	❑ NO
EAR SURGERY		
❑ Aesthetic & reconstructive ear surgery	❑ YES	❑ NO
❑ Otoplasty	❑ YES	❑ NO
❑ Traumatic repair	❑ YES	❑ NO
NOSE & THROAT SURGERY		
❑ Nasal septum-submucous resection and/or septoplasty	❑ YES	❑ NO
❑ Sinus surgery	❑ YES	❑ NO
❑ Turbinate surgery – conventional or KTP Laser	❑ YES	❑ NO
BREAST SURGERY		
❑ Abscess I & D	❑ YES	❑ NO
❑ Aesthetic & Reconstructive	❑ YES	❑ NO
❑ Biopsy	❑ YES	❑ NO
❑ Capsulectomy	❑ YES	❑ NO
❑ Gynecomastia	❑ YES	❑ NO
❑ Mastectomy, simple or subcutaneous	❑ YES	❑ NO
❑ Mastopexy, reduction mammoplasty w/ or w/o implant	❑ YES	❑ NO
❑ Plastic procedures (e.g., reconstruction mammoplasty, augmentation, reduction)	❑ YES	❑ NO
❑ Re-implantation	❑ YES	❑ NO

NEUROLOGICAL SURGERY		
❑ Nerve repair, resection and transfer or grafts (peripheral)	❑ YES	❑ NO
INTEGUMENTARY SURGERY		
❑ Repair of superficial lacerations	❑ YES	❑ NO
❑ I&D of superficial abscesses	❑ YES	❑ NO
❑ Excision of superficial benign cysts, lipoma or tumors	❑ YES	❑ NO
❑ Removal of superficial F.B.s	❑ YES	❑ NO
❑ Excision of cancer of skin	❑ YES	❑ NO
❑ Excision of pilonidal fistula or cyst	❑ YES	❑ NO
❑ Skin resection	❑ YES	❑ NO
❑ Reconstruction w/ flap and/or w/ graft	❑ YES	❑ NO
HAND SURGERY		
❑ Amputation of fingers or dislocations	❑ YES	❑ NO
❑ Repair of graft of nerves	❑ YES	❑ NO
❑ Arthrodesis	❑ YES	❑ NO
❑ Dislocations, hand – open reductions	❑ YES	❑ NO
❑ Repair tendons	❑ YES	❑ NO
❑ Reconstruction of soft tissues	❑ YES	❑ NO
❑ Repair of severed tendon	❑ YES	❑ NO
❑ Dislocations, hand – closed reduction only	❑ YES	❑ NO
❑ Uncomplicated fractures – closed reduction only	❑ YES	❑ NO
❑ Complex fracture, hand – closed reduction	❑ YES	❑ NO
❑ Fractures, hand – internal fixation	❑ YES	❑ NO
❑ Release of Dupuytren’s contractures	❑ YES	❑ NO
GRAFT		
❑ Small areas (1” diameter or less)	❑ YES	❑ NO
❑ Bone	❑ YES	❑ NO
❑ Cartilage	❑ YES	❑ NO
❑ Skin	❑ YES	❑ NO
❑ Fat	❑ YES	❑ NO
FLAPS		
❑ Immediate	❑ YES	❑ NO
❑ Delayed	❑ YES	❑ NO
❑ Myocutaneous	❑ YES	❑ NO

❑ Skin	❑ YES	❑ NO
❑ Fasciocutaneous	❑ YES	❑ NO
BIOPSY		
❑ Skin	❑ YES	❑ NO
❑ Muscle	❑ YES	❑ NO
❑ Lymph nodes	❑ YES	❑ NO
❑ Bones	❑ YES	❑ NO
❑ Fat	❑ YES	❑ NO
❑ Nerve	❑ YES	❑ NO
❑ Tendon	❑ YES	❑ NO
UROGENITAL		
❑ Aesthetic & reconstructive	❑ YES	❑ NO
OTHER		
❑ Skin cancer surgery	❑ YES	❑ NO
❑ Surgery for congenital deformities including cleft lip, cleft palate	❑ YES	❑ NO
❑ Maxillofacial injuries, reduction & fixation	❑ YES	❑ NO
❑ Breast surgery including total mastectomy, augmentation, reduction, and reconstruction	❑ YES	❑ NO
❑ Surgery for congenital and acquired deformities of the hands including acute trauma	❑ YES	❑ NO
❑ Reconstructive operations involving skin, fat, dermis, bone, and cartilage grafts and skin flaps and myocutaneous flaps	❑ YES	❑ NO
AESTHETIC SURGERY		
❑ Fat transfer	❑ YES	❑ NO
❑ Rhytidoplasty (face lift)	❑ YES	❑ NO
❑ Blepharoplasty	❑ YES	❑ NO
❑ Genioplasty	❑ YES	❑ NO
❑ Otoplasty	❑ YES	❑ NO
❑ Augmentation Mammoplasty	❑ YES	❑ NO
❑ Rhytidectomy (all areas)	❑ YES	❑ NO
❑ Suction assisted lipectomy (all areas)	❑ YES	❑ NO
❑ Rhinoplasty	❑ YES	❑ NO
❑ *Endoscopic Brow Lift	❑ YES	❑ NO
❑ Abdominal dermolipectomy w/ or w/o repair diastasis recti	❑ YES	❑ NO
❑ Umbilical herniorraphy	❑ YES	❑ NO

❑ Ventral herniorraphy	❑ YES	❑ NO
❑ Facial resurfacing	❑ YES	❑ NO
❑ Chemical Peel	❑ YES	❑ NO
❑ Dermabrasion	❑ YES	❑ NO
❑ Injection (Botox, Collagen, Dermologen)	❑ YES	❑ NO
LASER SURGERY		
❑ *KTP Laser	❑ YES	❑ NO
❑ *CO^2 Laser	❑ YES	❑ NO
❑ *Erbium	❑ YES	❑ NO
❑ *Nd:YAG Laser	❑ YES	❑ NO
❑ *Versapulse/pulsed dye laser	❑ YES	❑ NO
❑ *Other Laser:	❑ 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 recommended

_____ _____
Signature of Governing Body chairperson Date recommended