APPLICANT NAME:_____

GENERAL SURGERY PRIVILEGES

I hereby request surgical privileges in the specialty of General 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.

Applied for	Approval	
❑ *Cholecystectomy - Laparoscopic	❑ YES	❑ NO
❑ Liver Biopsy	❑ YES	❑ NO
❑ Hemmorrhoids, Ulcers, Fistulas, Abscesses	❑ YES	❑ NO
❑ Pilonidal	❑ YES	❑ NO
❑ Cystectomy	❑ YES	❑ NO
❑ Fistulectomy	❑ YES	❑ NO
❑ Hernias	❑ YES	❑ NO
❑ Femoral	❑ YES	❑ NO
❑ *Inguinal – Laparoscopic	❑ YES	❑ NO
❑ Ventral	❑ YES	❑ NO
❑ Incisional	❑ YES	❑ NO
❑ Umbilical	❑ YES	❑ NO
❑ Vasectomy	❑ YES	❑ NO
❑ Hydrocelectomy	❑ YES	❑ NO
❑ Circumcision	❑ YES	❑ NO
❑ Breast Biopsy	❑ YES	❑ NO
❑ Lymphadenectomy, node biopsy	❑ YES	❑ NO
❑ Plastic	❑ YES	❑ NO
❑ Excision Skin Lesions	❑ YES	❑ NO
❑ Grafts, simple	❑ YES	❑ NO
❑ Scar Revisions	❑ YES	❑ NO
❑ Tendon Repair	❑ YES	❑ NO
❑ *Rotation or Pedicle Flaps (minor)	❑ YES	❑ NO
❑ Amputations	❑ YES	❑ NO
❑ Minor (Fingers, Toes)	❑ YES	❑ NO
❑ Endoscopy	❑ YES	❑ NO
❑ Upper GI Endoscopy	❑ YES	❑ NO
❑ Colonoscopy	❑ YES	❑ NO
❑ Colonoscopy with biopsy	❑ YES	❑ NO

❑ Indwelling Venous Access (Porta Cath or Hickman Catheter)	❑ YES	❑ NO
❑ *Lasers	❑ YES	❑ NO
❑ *Nd:YAG laser, CO2 laser	❑ YES	❑ NO
❑ Hemorrhoidectomy	❑ YES	❑ NO
❑ Laser Angioplasty	❑ 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
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

** DOCUMENTATION OF TRAINING AND EXPERIENCE IS REQUIRED FOR THOSE PROCEDURES*

Signature of Applicant _____ Date _____

Signature of QI Committee Chairperson _____ Date _____

Signature of Governing Body Chairperson _____ Date _____