

Hand/Upper Extremities Surgery

Name: _____

MEDICAL STAFF CATEGORY REQUESTED:

- Active – Active staff members shall provide service to a minimum of 48 patients in their two year appointment period; shall participate in the quality/performance management activities; and shall also provide on-call coverage for medical emergencies.*
- Courtesy - Courtesy staff members shall provide service to a minimum of 6 patients in their two year appointment period; shall be members of the active or associate staff of another hospital in which their regular participation in quality/performance management activities is documented and their performance is evaluated.*
- Consulting – Consulting staff does not have a minimum patient requirement; shall consist of members who meet the general qualifications set forth in the Bylaws; will provide limited services; and are required to practice with another fully privileged member of the medical staff.*

Qualifications:

To be eligible for privileges in hand surgery, the applicant must meet the following qualifications:

- Requires completion of a one (1) year accredited Hand Fellowship program and documentation of at least 100 hand and upper extremities procedures during the past two years.
- Successful completion of an ACGME or AOA accredited residency in general surgery, orthopedic surgery or plastic surgery that includes training in surgery of the hand and upper extremities. **and**
- Current certification in plastic surgery, general surgery or orthopedic surgery and subspecialty certification or eligibility to participate in the examination process leading to certification in hand surgery by the American Board of Plastic Surgery; American Board of Orthopedic Surgery; American Board of Surgery; or the American Osteopathic Board of Surgery.

Hand Surgery Privileges (Please indicate with a check mark the privileges requested)

- Admit; evaluate; diagnose; provide pre-, intra-, and postoperative surgical treatment to patients of all ages- except where specifically excluded from practice and except for those Special Procedure Privileges-to correct or treat various conditions, and injuries of the Hand and Upper Extremity.
- Amputation, arthrodesis, arthroscopic, and reduction of fractures, including the provision of consultation.
- Amputation surgery including immediate prosthetic fitting in the operating room
- Amputations/simple polydactyly/digital tip injuries
- Arthrocentesis, diagnostic
- Arthrodesis, osteotomy, and ligament reconstruction of the major peripheral joints, excluding total replacement of joint
- Arthrography
- Arthroscopic surgery
- Biopsy and excision of tumors involving bone and adjacent soft tissues
- Bone grafts and reconstructive procedures for wounds including pedicle, free flaps and skin grafts
- Carpal tunnel decompression: open and endoscopic
- Close reduction of fractures and dislocations of the peripheral skeleton
- Correction and reconstructive surgery of the skeleton, Fasciotomy and fasciectomy

- Microvascular and micronerve surgery
- Growth disturbances such as injuries involving growth plates with a high percentage of growth arrest, growth inequality, epiphysiodesis, stapling, bone shortening or lengthening procedures
- Management of infections and inflammations of bones, joints, and tendon sheaths
- Open and closed reduction of fractures
- Open reduction and internal fixation of fractures and dislocations of the peripheral skeleton
- Reconstruction on nonspinal congenital musculoskeletal anomalies
- Arthroplasty of digits, wrist and elbow, including joint replacement
- Removal of ganglion
- Manipulation under anesthesia
- Operate X-Ray equipment
- Read own X-Rays, note findings in operative report.
- Procedures on tendons including repair, transfer, and grafting

If the procedure that you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and experience.

Acknowledgement of practitioner:

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at **Harris Methodist Southlake**, and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed: _____

Date: _____

Credentials Committee Recommendations: _____ Recommend _____ Deny

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Signed: _____

Date: _____

Recommended/Not recommended with the following modification(s) and reason(s):

