

Orthopedic 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 orthopedic surgery, the applicant must meet the following qualifications:

- Documentation of the performance of at least 100 orthopedic procedures during the last two years or successful completion of a hospital-affiliated formalized residency or clinical fellowship in the past two years; **and**
- Current certification or eligibility to participate in the examination process leading to certification in orthopedic surgery by the American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery; **and**
- Successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery.

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

- Admit, evaluate, diagnose, and provide non-surgical and surgical care to patients and to correct or treat various conditions, illnesses, and injuries of the musculoskeletal system.
- Amputation surgery, including immediate prosthetic fitting in the operating room
- Amputations/simple polydactyly/digital tip injuries
- Arthrodesis, osteotomy, and ligament reconstruction of the major peripheral joints
- Arthrodesis, any joint
- Application of splints and casts
- Arthrography
- Arthrocentesis and injection of joints, bursae, and cysts
- Arthroscopic surgery
- Soft tissue procedures including simple suture, debridement of wounds, excision of bursae, removal of foreign bodies, I&D of acute or chronic infections
- Biopsy and excision of tumors soft tissue and bone, from extremities, back and neck, not requiring major bone or joint reconstruction
- Tendon fixation, suture and transplants
- Bone grafts

- Arthrotomies of any joints
- Synovectomy any joint
- Hip and shoulder hemi-arthroplasty
- Surgical correction of nerve entrapment syndromes
- Major arthroplasty including total replacement of joints
- Repair or reconstruction of ligament ruptures, any joint
- Osteotomy, any bone
- Excision of bones or portions of bone
- Carpal tunnel decompression
- Closed reduction of fractures and dislocations of the peripheral skeleton
- Correction and reconstructive surgery of the axial skeleton, excluding spine
- Fasciotomy and fasciectomy
- Fractures and dislocations of the pelvis and acetabula
- Bone drilling operations
- Skin grafts as related to orthopedic problems
- 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
- Removal of ganglion (palm or wrist; flexor sheath)
- Manipulation under anesthesia
- Operate X-Ray equipment
- Read own X-Rays, note findings in operative report.

Areas of Specialization:

Please check one or more of the age groups listed below:

- Children 2 to 12 years
- Adolescents 13 to 17
- Adults 18 years and greater

Please check one or more of the areas of specialization listed below:

- Knee, including thigh/femur and leg/tibia and fibula
- Hip/Pelvis, including thigh/femur
- Shoulder, including arm/humerus
- Elbow, including arm/humerus and forearm/radius and ulna
- Foot/Ankle, including leg/tibia and fibula
- Hand/Wrist, including forearm/radius and ulna

Special procedures privileges (Please indicate with a check mark the privileges requested)

To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure within the last 2 years, consistent with the criteria set forth here.

Procedure	Criteria	Requested	Recommended	Not Recommended
Vascular grafts of the hands and forearm	6 cases			
Endoscopic assisted carpal tunnel decompression	6 cases			
Major spinal surgery including anterior or posterior with or without the use of internal fixation devices, vertebral body resection, spinal fusion, laminectomy	10 cases			

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):
