Texas Health Harris Methodist Hospital SOUTHLAKE

Podiatric 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 podiatry, the applicant must meet the following qualifications:

- Documentation of the performance of at least 50 podiatric surgical procedures in the past two years; and
- Graduated from an accredited four-year podiatric medical college and completed a minimum one-year podiatric CPME-approved surgical residency program;
  - Current certification or eligibility to participate in the examination process leading to certification by the National Podiatric Boards (Part I and Part II, & Part III); and
  - Current licensure by the T.S.B.P.M.E. (The Texas State Board of Podiatric Medical Examiners)

Podiatry Surgical Privileges (Please indicate with a check mark the privileges requested)

- ☐ Admit; evaluate; diagnose; provide pre-, intra-, and postoperative podiatric treatment and surgical management to patients of all ages—except where specifically excluded from practice and except for those special procedure privileges listed below—to correct or treat various conditions, and injuries of the foot.
- ☐ Perform the part of the history and physical examination related to any podiatric problem justifying the reason for admission;
- ☐ Provide consultation,
- ☐ Order diagnostic studies
- ☐ Procedures to nail matrix, metatarsals, tarsals, fascia, tendons of forefoot, soft tissue and bunions.
- ☐ Soft Tissue Surgery
  - ☐ Incision of skin and subcutaneous lesions
  - ☐ Excision of skin and subcutaneous lesions
  - ☐ Destruction of skin or nail lesions
- ☐ 2nd-5th Metatarsal and Phalanges Surgery (Osseus and Soft Tissue Surgery)

- ☐ Repair including plasties and grafting (If skin or bone grafts are to be retrieved from other portions of the body, a Medical Staff appointee with surgical privileges is required to perform this.)
- ☐ Incision
- ☐ Excision
- ☐ Manipulation of fractures: Close reduction, Open reduction, Open fractures
- ☐ Amputation throught MTP (metatarsal phalangeal) joint or distal

☐ First Metatarsal and Phalanx Surgery (Osseus and Soft Tissue Surgery)

- ☐ Repair including plasties and grafting grafting (If skin or bone grafts are to be retrieved from other portions of the body, a Medical Staff appointee with surgical privileges is required to perform this.)
- ☐ Incision
- ☐ Excision
- ☐ Manipulation of fractures: Close reduction, Open reduction, Open fractures
- ☐ Amputation throught MTP (metatarsal phalangeal) joint or distal
- ☐ Bunionectomy: With or without first metatarsal osteotomy

☐ Hindfoot Surgery

- ☐ Resection of Haglund's deformity
- ☐ Excision of heel spur
- ☐ Plantar fascial release

☐ Infections

- ☐ Debridement (Antibiotic therapy requires consult with a physician Medical Staff member if the patient does not respond in a timely manner.)

☐ Operate X-ray equipment

☐ Read own x-rays, note findings in operative report

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 be Board Qualified status in Reconstructive Rearfoot/Ankle Surgery (RRA) Surgery or by the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) ; Or
Demonstrate successful completion of a CPME-approved Reconstructive Rearfoot/Ankle Surgery program (PSR-24 or greater) or a CPME-approved Residency in Podiatric Medicine and Surgery-36; Or
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	Recom-mended	Not Recom-mended
Group A*	6 cases from this group			
Open repair of fracture, ankle**	6 cases			
Repair of clubfoot	10 cases			
Tendon transfer or redirection of mid-tarsus, rearfoot	6 cases			
Ankle Scope**	10 cases			
Endoscopic Plantar Fasciotomy	10 cases			

*Group A: Please indicate with a check mark the privileges requested

- ☐ Malignancy

- ☐ Soft tissue, excision and biopsy
- ☐ Bone, excision and biopsy limited to the forefoot

☐ Implants
- ☐ Implant in 1st – 5th metatarsal phalangeal joint

☐ Amputations
- ☐ Forefoot (Chopart or Lisfranc or trans-metatarsal

☐ Hindfoot
- ☐ Subtalar fusion
- ☐ Triple arthrodesis

**Procedures not available to new applicants or as additional procedures for current practitioners.

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):

_____

_____