Hospital Logo

Hospital Name

Hospital Address

**Application for Clinical Privileges – Podiatry**

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| Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff Category: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Effective from \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Request all privileges desired by checking the applicable requested box.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Request | Not Requested |  | Granted | Not Granted |
|  |  | Evaluate, diagnose, treat and manage patients of all ages with disorders of the foot and/or ankle |  |  |
|  |  | Admit patients to the appropriate level of care |  |  |
|  |  | **Podiatric Surgical Procedures (involving foot, ankle): Remove those procedures not within the capabilities and capacities of Hospital** |  |  |
|  |  | Administration of local anesthesia, regional or nerve block |  |  |
|  |  | Amputation of digit |  |  |
|  |  | Arthrocentesis |  |  |
|  |  | Arthrodesis digital (metatarsal and tarsal) |  |  |
|  |  | Arthroplasty of digit (metatarsal and tarsal) |  |  |
|  |  | Debridement of abscess or ulceration |  |  |
|  |  | Electrosurgical destruction of skin lesions with or with surgical curettement |  |  |
|  |  | Excision of benign nerve tumor (i.e., Morton’s Neuroma) |  |  |
|  |  | Excision of skin lesions and tumors |  |  |
|  |  | Excision of soft tissue lesions and tumors |  |  |
|  |  | Hallux Valgus and Hallux Varus repair |  |  |
|  |  | Hardware removal |  |  |
|  |  | Implantation of foreign material (i.e., internal fixation, silicone joint implants), digital, metatarsal and/or tarsal |  |  |
|  |  | Incision and drainage of onchia, paronchia |  |  |
|  |  | Incision and drainage of subcutaneous abscess or hematoma |  |  |
|  |  | Intraoperative use of C-arm |  |  |
|  |  | Metatarsectomy, partial or complete |  |  |
|  |  | Onychoplasty |  |  |
|  |  | Open/closed reduction of fracture/dislocation |  |  |
|  |  | Osteotomy with or without internal fixation digit, metatarsal or tarsal |  |  |
|  |  | Partial or total matricectomy with or without subungual exostectomy |  |  |
|  |  | Removal of foreign body |  |  |
|  |  | Sesamoidectomy, partial or complete |  |  |
|  |  | Surgical repair of lacerations |  |  |
|  |  | Tendon transfer |  |  |
|  |  | Tenotomy or tendon lengthening |  |  |
|  |  | Treat cases of non-union |  |  |
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|  |  |  |  |  |
|  |  | Other Privileges Desired (Not Listed Above) |  |  |
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**Signature of Applicant:**

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I am entitled to perform and that I wish to exercise at (Insert Name of Hospital).

I also understand that by making this request I am bound by the applicable Medical Staff Bylaws and/or policies of (Insert Name of Hospital). I also attest that my professional liability insurance covers the privileges I have requested.

I understand that it is my responsibility to provide (Insert Name of Hospital) with documentation of my education, training, current experience and information regarding the number of services and procedures I have performed in order to assist the Medical Staff in the determination of competency or continued competency.

I affirm that I will obtain a consultation with a qualified medical staff member when it is in the best interest of the patient and/or when my expertise does not meet the clinical needs of the patient.

Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws and related documents.

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**Signature of Applicant Date**

**Medical Staff/Credentials Committee Recommendations – Privileges**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s): Please check the applicable box(es)

|  |  |
| --- | --- |
|  | Recommend all requested privileges |
|  | Do not recommend any of the requested privileges |
|  | Recommend privileges with the following conditions/modifications/deletions (listed below) |

|  |  |
| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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**Medical Staff/Credentials Committee Date**

**Board of Directors Determination**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following determination(s): Please check the applicable box(es).

|  |  |
| --- | --- |
|  | Approve all requested privileges |
|  | Approve none of the requested privileges |
|  | Approve the following privileges with the following conditions/modifications/deletions (listed below) |

|  |  |
| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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Board of Directors Date

Hospital Name

Form Approved By:

Medical Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Board of Directors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date