



Providence Hospital  
of North Houston

**Providence Hospital of North Houston**

16750 Red Oak Drive  
Houston, Texas 77090

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Privilege Request Form –Orthopedic Surgery**

**SECTION I – GENERAL REQUIREMENTS ORTHOPEDIC SURGERY**

**Requested STAFF CATEGORY**

\_\_\_\_\_ Active      \_\_\_\_\_ Courtesy      \_\_\_\_\_ Consulting      \_\_\_\_\_ Affiliate

**INITIAL APPOINTMENT**

Basic Education;      MD or DO

**Minimum Formal Training and experience:**

- Successful completion of an ACGME or AOA accredited residency in Orthopedic Surgery.
- Member in good standing of an accredited acute care hospital and/or ambulatory surgery center, with the same or similar unrestricted privileges.
- The number of cases performed in the last 12 months for each procedure requested along with the documentation of proficiency must be sufficient to validate competence. An applicant who has just completed a residency shall provide his/her residency log. Additional documentation and monitoring may be required at the discretion of the Medical Director or the Chief of Staff. Some procedures may require additional documentation of training and experience which is acceptable to the Medical Director such as Proctoring Reports, Operative Reports and Discharge Summaries for other institutions, written communication of documents from the Chairperson of the designee of an approved academic training program, approved continuing medical education course, or clinical department from another institution attesting to completion of a specified course of training, and/or the number of the specified successful procedures performed, and/or the applicants known ability to perform a specific procedure for which the applicant has previously been formally trained to carry out in an approved program.
- Evidence of Board Certification or eligibility in Orthopedic Surgery by the American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery is preferred.
- Interview by the Medical Director and/or Chief of Staff when requested

**FOR ADVANCED LAPAROSCOPY**

- Privileges for the corresponding open procedure; **AND**
- Previous operative experience, documentation of experience (operative reports) adequate to justify



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the privileges being requested; **OR**

- For those without previous operative experience, an advanced laparoscopic surgery course with animate, hands-on training and experience serving as first assistant or documentation of training with an experienced surgeon.
- The first two (2) patient cases may be proctored by an experienced surgeon skilled in the procedure.

**REAPPOINTMENT MAINTENCE OF PRIVILEGE**

- Demonstrated evidence of clinical activity from relevant professional practice evaluation during the past 24 months without significant quality variations, OR
- Peer recommendations when performance data is insufficient at the time of reappraisal; and
- Ongoing maintenance of continuing medical education as it pertains to scope of license and specialty.

**SECTION II – PRIVILEGES REQUESTED**

| Basic Procedure  | Requested | Granted | Denied |
|--|-----------|---------|--------|
| Admit patients   |           |         |        |
| Perform History & Physical Exam  |           |         |        |
| Post-surgical evaluation and treatment   |           |         |        |
| Medical management of post-surgical patients using prudence and good medical judgment for appropriate consultation |           |         |        |

| PRIVILEGES:                                 | # of cases<br>in the past<br>12 months | Requested | Approved | Denied |
|---|--|-----------|----------|--------|
| ACL reconstruction                          |  |           |          |        |
| Amputation finger/toe                       |  |           |          |        |
| Arthrodesis                                 |  |           |          |        |
| Arthroscopy ___ Knee ___ Shoulder ___ Ankle |  |           |          |        |
| Arthroplasty                                |  |           |          |        |



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| <b>PRIVILEGES:</b>                            | <b># of cases<br/>in the past<br/>12 months</b> | <b>Requested</b> | <b>Approved</b> | <b>Denied</b> |
|---|---|------------------|-----------------|---------------|
| Arthrotomy                                    |   |                  |                 |               |
| Bone grafts                                   |   |                  |                 |               |
| Bunionectomy                                  |   |                  |                 |               |
| Bursectomy                                    |   |                  |                 |               |
| Carpal tunnel release                         |   |                  |                 |               |
| Cast application                              |   |                  |                 |               |
| Closed reduction                              |   |                  |                 |               |
| De Quervain's release                         |   |                  |                 |               |
| Excision bony lesion                          |   |                  |                 |               |
| Ganglionectomy                                |   |                  |                 |               |
| Hammertoe repair                              |   |                  |                 |               |
| Hardware removal                              |   |                  |                 |               |
| I&D abscess                                   |   |                  |                 |               |
| Joint and tendon prosthesis                   |   |                  |                 |               |
| Ligament repair                               |   |                  |                 |               |
| Manipulation of joint                         |   |                  |                 |               |
| Meniscectomy                                  |   |                  |                 |               |
| Neuroma excision                              |   |                  |                 |               |
| Open reduction                                |   |                  |                 |               |
| ORIF - extremity                              |   |                  |                 |               |
| Peripheral nerve surgery                      |   |                  |                 |               |
| Skin graft and flaps                          |   |                  |                 |               |
| Synovectomy                                   |   |                  |                 |               |
| Tendon repair                                 |   |                  |                 |               |
| Tenolysis                                     |   |                  |                 |               |
| Trigger finger release                        |   |                  |                 |               |
| Tumor excision                                |   |                  |                 |               |
| Interpret x-rays                              |   |                  |                 |               |
| <b>Hand Surgery</b>                           |   |                  |                 |               |
| Surgery of muscle, tendon, and fascia of hand |   |                  |                 |               |



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| <b>PRIVILEGES:</b>  | <b># of cases<br/>in the past<br/>12 months</b> | <b>Requested</b> | <b>Approved</b> | <b>Denied</b> |
|---|---|------------------|-----------------|---------------|
| Transplantation of muscle and/or tendon of hand                   |   |                  |                 |               |
| Plastic operation on hand with tissue graft or prosthetic implant |   |                  |                 |               |
| Other (Please be specific)  |   |                  |                 |               |

\*If you anticipate administering your own anesthesia, please complete the Moderate Sedation Privilege Request Form.

**I have been approved for these procedures at the following hospitals/ambulatory surgery centers:**



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**SECTION III - ACKNOWLEDGEMENT OF PRACTITIONER**

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at the Hospital. I hereby attest that the references, reports, records, and information are available that verify my qualifications and competency to practice general surgery or any other special privileges I have requested and to perform the requested procedures.

I understand that:

1. In exercising any clinical privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
2. 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.
3. The use of any other new, untried, or unproven procedure/treatment modality/instrumentation maybe performed or used, only after the regular credentialing process has been completed and the privilege to perform or use said procedure/treatment modality/instrumentation has been granted to the individual practitioner.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date



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**SECTION IV – RECOMMENDATIONS AND APPROVALS**

**Recommendation of Medical Director:**

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

\_\_\_\_ Approval of all requested privileges

\_\_\_\_ Approval of the following privileges with conditions:

\_\_\_\_\_

\_\_\_\_ Denied of the following privileges:

\_\_\_\_\_

\_\_\_\_\_  
Medical Director

\_\_\_\_\_  
Date

**Recommendation of the Medical Executive Committee:**

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

\_\_\_ Approval of all requested privileges

\_\_\_ Approval of the following privileges with conditions:

\_\_\_\_\_

\_\_\_ Denied of the following privileges:

\_\_\_\_\_

\_\_\_\_\_  
Chief of the Medical Staff

\_\_\_\_\_  
Date



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**Decision of the Governing Board:**

The governing Board has reviewed the above recommendations regarding the requested clinical privileges and supporting documents for the above named applicant and:

Grant all requested privileges

Grant the following privileges with conditions:

\_\_\_\_\_

Deny the following privileges:

\_\_\_\_\_

\_\_\_\_\_  
**Chairman of the Board**

\_\_\_\_\_  
**Date**