Providence Hospital
of North Houston

____________________________________ ________________________
Print Name Date

Privilege Request Form –Spine Surgery

SECTION I – GENERAL REQUIRERMENTS ORTHOPEDIC SPINE SURGERY

INITIAL APPOINTMENT

Basic Education; MD or DO

Minimum Formal Training and experience:

- Successful completion of an ACGME or AOA accredited residency in Orthopedic Surgery, followed by successful completion of an accredited fellowship in Orthopedic Surgery of the Spine, completion of resident training and experience deemed by the American College of Spine Surgery to be equivalent to a 12 month approved spine fellowship program, or current certification by the American Board of Spine 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 Neurology Spine by the American Board of Specialties or the American Osteopathic Board of Orthopedic Surgery –Spine 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 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.

Print Name ______________________ Date ______________________

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 in the past 12 months	Requested	Approved	Denied
ACL reconstruction				
Amputation finger/toe				
Arthrodesis				
Arthroscopy ___ Knee___ Shoulder ___ Ankle				
Arthroplasty				
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 prothesis				

Providence Hospital
of North Houston

______________________________ ____________________
Print Name Date

PRIVILEGES:	# of cases in the past 12 months	Requested	Approved	Denied
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				
Hand Surgery				
Surgery of muscle, tendon, and fascia of hand				
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 indicate below; if request "Yes" you are required to complete the Moderate Sedation Privilege Request Form and Quiz.

☐ **Yes**
☐ **No**

Providence Hospital
of North Houston

______________________________ ______________________

Print Name Date

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 may be 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**

Providence Hospital
of North Houston

______________________________ ____________________
Print Name Date

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**

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**