Hospital Logo

Hospital Name

Hospital Address

**Application for Clinical Privileges – Orthopedic Surgery**

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

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

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| --- | --- | --- | --- | --- |
| Request | Not Requested |  | Granted | Not Granted |
|  |  | Evaluate, diagnose, treat, and provide consultation to patients of all ages to correct or treat various conditions, illnesses, and injuries of the extremities, spine, and associated structures by medical, surgical and physical means, including but not limited to congenital deformities, trauma, infections, rumors, metabolic disturbances of the musculoskeletal system, deformities, injuries, and degenerative disease of the spine, hands, feet, knee, hips, shoulders, and elbows, including primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system. |  |  |
|  |  | Admit to the appropriate level of care. |  |  |
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|  |  | **Procedures: Remove those procedures not within the capabilities and capacities of Hospital (Note: This list should be expanded to reflect the capabilities and capacities of the hospital)** |  |  |
|  |  | Joint Injections |  |  |
|  |  | Joint Aspirations |  |  |
|  |  | Skeletal procedures including stabilization of fractures and dislocations; immobilization techniques; reduction techniques (Need appropriate description) |  |  |
|  |  | Wound irrigation and debridement |  |  |
|  |  | Carpal tunnel, endoscopic |  |  |
|  |  | Carpal tunnel, open |  |  |
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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) |

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| 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) |

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| --- | --- |
| 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