

Huntington Memorial Hospital

Delineation Of Privileges Orthotics & Prosthetics

Provider Name:

Privilege	Requested	Deferred	Approved
-----------	-----------	----------	----------

Job Description:

Under supervision of the employing physician, the Orthotist designs and fits devices, known as orthoses, to provide care to patients who have disabling conditions of the limbs and spine. Under supervision of the employing physician, the Prosthetist designs and fits devices, known as protheses, for patients who have partial or total absence of a limb.

Qualifications:

1. Completion of an accredited program for the Orthotist and/or Prosthetist.
2. Certification by the American Board of Certification in Orthotics and Prosthetics, Inc

1. Orthotic Privileges: Measurement, impression taking, model rectification, fitting and alignment of orthoses for lower limb, upper limb and spine. Systems will include foot orthosis, ankle-foot orthosis, knee orthosis, knee ankle-foot orthosis, hip knee-ankle orthosis, hip orthosis, wrist-hand orthosis, shoulder-elbow orthosis, cervical orthosis, cervico-thoracic-lumbo sacral orthosis, thoraco-lumbo-sacral orthosis, lumbo-sacral orthosis, HALO, fracture management, RGO, standing frames and seating. ___ ___ ___

2. Prosthetic Privileges: Measurement, impression taking, model rectification, diagnostic fitting, definitive fitting, postoperative management, external power, and static and dynamic alignment of sockets related to various amputation levels, including partial foot, Syme's, below-knee, above-knee, below-elbow, above-elbow and the various joint disarticulations. ___ ___ ___

ACKNOWLEDGEMENT OF THE ALLIED HEALTH PROFESSIONAL:

I have requested only those privileges for which I am qualified to perform, based upon my education, training, current experience and demonstrated performance. I understand that in exercising my practice privileges granted, I am constrained by hospital and medical staff policies and rules, including those outlined in the Allied Health Professional Rules and Regulations.

Signature of AHP: _____ Date: _____

Signature of Supervising Physician: _____ Date: _____

INTERDISCIPLINARY PRACTICE COMMITTEE RECOMMENDATION:

I have reviewed the requested practice privileges and supportive documentation for the above names applicant and

Huntington Memorial Hospital

Delineation Of Privileges Orthotics & Prosthetics

Provider Name:

Privilege	Requested	Deferred	Approved
-----------	-----------	----------	----------

recommend action on the privileges as noted above.

Applicant may perform practice privileges as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

APPROVALS

Interdisciplinary Practice Committee: _____ Date: _____

Medical Executive Committee Date: _____

Board of Directors Date: _____