Huntington Hospital

Delineation Of Privileges

Podiatry Privileges

Provider Name:

Privilege	Requested	Tabled	Approved

PODIATRY PRIVILEGES

Criteria - New Applicants: Board Certified or qualified for certification by the American Board of Podiatry.
Criteria - Current Staff Members Only: Successful completion of an approved training program; OR demonstrated acceptable practice in the privileges being requested for a minimum of five (5) years.
Proctoring Requirements: A minimum of eight cases, in accordance with the Surgery Department Proctoring Protocol.

GENERAL PRIVILEGES:

Consultation Only Privileges ___ ___ ___

Surgical Assist Only ___ ___ ___

CORE PRIVILEGES - PODIATRY: ___ ___ ___
Includes the management and coordination of care, treatment and services, including: Medical History and Physical examinations related to the foot, consultations, and prescribing medication in accordance with DEA certificate.

Procedures as related to the foot:

Arthrodesis ___ ___ ___

Bunionectomy ___ ___ ___

Bursectomy ___ ___ ___

Capsulectomy ___ ___ ___

Cast Change ___ ___ ___

Closed Reduction Fracture ___ ___ ___

Debridement ___ ___ ___

Excision Exotosis ___ ___ ___

Foreign Body Excision ___ ___ ___

Fusion ___ ___ ___

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Provider Name:

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Ganglionectomy	___	___	___
Hammertoes Correction	___	___	___
Hardware Removal	___	___	___
Ligament Repair	___	___	___
Manipulation of Joints	___	___	___
Mass Excision	___	___	___
Morton's Neuroma Removal	___	___	___
Nerve Repair - Toe	___	___	___
Neurolysis - Toe	___	___	___
Neuroma Removal	___	___	___
Open Reduction Fracture	___	___	___
Osteotomy	___	___	___
Phalangectomy	___	___	___
Plantar Wart Excision	___	___	___
Scar Revision	___	___	___
Sequestrectomy	___	___	___
Syndactylization of Toes	___	___	___
Synovectomy	___	___	___
Tarsal Tunnel Decompression	___	___	___
Tendon Release Tenotomy	___	___	___

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Privilege	Requested	Tabled	Approved
Tendon Repair	___	___	___
Tendon Sheath Release	___	___	___
Tenosynovectomy	___	___	___
Toenail Removal	___	___	___
Xanthroma Excision	___	___	___
Z-Plasty	___	___	___

SUPPLEMENTAL PRIVILEGES - PODIATRY

Criteria:

Must meet the criteria outlined for Core Podiatry privileges, and the specific criteria defined for the Supplemental privilege.

SUPPLEMENTAL PRIVILEGES - PODIATRY:

CO2 Laser Privileges ***Criteria***: Requires evidence of training or laser certificate.	___	___	___

Revised 7/22/10

ACKNOWLEDGEMENT OF THE PRACTITIONER:

I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at Huntington Hospital, and I understand that: a) in exercising my clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation; b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature of Applicant: _____ Date:_____

DEPARTMENT CHAIR RECOMMENDATIONS

Huntington Hospital

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I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Applicant may perform privileges and procedures as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

APPROVALS:

Section Chair: _____ Date: _____

Department Chair: _____ Date: _____

Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____