**Surgicore**

of Jersey City LLC

DELINEATION OF PRIVILEGES: ***PODIATRIC SURGERY***

I am requesting Podiatric Surgery privileges for:

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| --- | --- | --- | --- |
| **Requested** | **Not Req.** | **Granted** | **Procedure** |
| **🞏** | **🞏** | **🞏** | **Correct or treat various conditions, illnesses, and injuries to the digital, forefoot, and simple rear-foot procedures** |
| **🞏** | **🞏** | **🞏** | **Correct or treat various conditions, illnesses, and injuries of the rear foot, ankle, including Achilles tendon lengthening repair, and or gastrocnemius recession** |
| **🞏** | **🞏** | **🞏** | **All soft tissue and bony procedures involving the phalanges and metatarsal bones distal to the tarso-metatarsal joint** |
| **🞏** | **🞏** | **🞏** | **All soft tissue and bony procedures involving the cuneiform, navicular, and cuboid bones distal to the mid-tarsal joint** |
| **🞏** | **🞏** | **🞏** | **All soft tissue and simple exostectomy procedures involving the talar and calaneal bones distal to the ankle joint, such as haglund’s resection and simple tendon repairs** |
| **🞏** | **🞏** | **🞏** | **All soft tissue, simple exostectomy, anthroscopy and drill hole (for ankle ligamentous reconstruction) procedures involving the distal tibia and fibular bones** |
| **🞏** | **🞏** | **🞏** | **Procedures involving osteotomies, arthrodesis, and open repair of fractures of the talar and calcaneal bones distal to the ankle joint and the ankle joint** |
| **🞏** | **🞏** | **🞏** | **Operation, interpretation and reporting of X-ray and C-arm imaging** |
| **🞏** | **🞏** | **🞏** | **Administration of local anesthesia** |
| **🞏** | **🞏** | **🞏** | **Admission to overnight care services** |

*SPECIAL PROCEDURES / TECHNIQUES:* To be eligible to apply for a special procedure listed below, you must demonstrate successful completion of an approved, recognized course, OR provide documentation of competence in performing that procedure (i.e. provide ten (10) operative reports for that same procedure), OR provide current Delineation of Privileges from a Hospital to perform that same procedure.

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| --- | --- | --- | --- |
| **Requested** | **Not Req.** | **Granted** | **Procedure** |
| **🞏** | **🞏** | **🞏** | **Laser – CO2** |
| **🞏** | **🞏** | **🞏** | **Other: 1.** |
| **🞏** | **🞏** | **🞏** | **2.** |
| **🞏** | **🞏** | **🞏** | **3.** |

I agree to admit patients, perform histories and physicals, order diagnostic tests, request consultations, provide consultations within the scope of my privileges, use all skills normally learned during medical school and residency, and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the facility.

I will practice within the bounds of my training and competence and will not attempt to treat cases which are not in my scope of practice. I understand that any newly developed treatment modalities are not included in this request and must be cleared by the Medical Executive Committee and Governing Board before their performance. I will become familiar with the capabilities and limitations of this Facility.

I understand that in making this request I am bound by the applicable Bylaws and/or Policies & Procedures of Surgicore of Jersey City LLC, and hereby stipulate that I meet the threshold criteria for this request. I also certify that I have knowledge to operate all the equipment necessary to carry our requested procedures.

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Applicant’s Name Printed | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Applicant’s Signature |
|  |  |  |

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Above privileges, as requested, are recommended to the Board of Directors for formal approval to work at the center.

**Granted \_\_\_\_\_\_\_ Deferred \_\_\_\_\_\_\_\_ *Medical Director* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Granted \_\_\_\_\_\_\_ Deferred *\_\_\_\_\_\_\_\_ Administrator* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

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