



GREATER LANSING

DEPARTMENT OF SURGERY
GENERAL SURGERY SECTION

Privilege Request Form

Applicant's Name: _____
(Please Print)

DIRECTIONS: This Privilege Request Form must accompany all initial applications for appointment to the General Surgery Section, Department of Surgery. Please indicate those privileges that apply to your surgical practice. NOTE: All level III privileges require additional documentation that must accompany such requests.

LEVEL I: Those procedures assured by competent practitioners upon completion of an accredited residency program. No separate monitoring required.

Level I Privileges Requested: [] All [] Partial (as checked below)

- Diagnostic & therapeutic procedures as requested, including:
Cutdown procedures
Endotracheal intubation and emergency respiratory support
Excision of simple <5 cm skin lesions and closure of wounds <10 cm
Insertion and evaluation of IV needles and catheters
Lumbar puncture
Therapeutic phlebotomy
Sigmoidoscopy - rigid and flexible with/without biopsy
Thoracentesis - simple needle or small catheter <6F
Paracentesis (as above)
*Other: (specify)

*Additional procedures require consideration/approval of the Department.

LEVEL II: Those procedures assured by competent practitioners upon completion of accredited residency programs in general surgery. Requires separate monitoring - see General Surgery Credentialing Policy.

Level II Privileges Requested: [] All [] Partial (as checked below)

Surgery of the Skin and Subcutaneous Tissue:

- Excision of benign and malignant lesion
Repair and reconstruction of simple and complex lacerations
Skin grafts and skin flaps
Treatment of burns, not requiring admission

Breast:

- Excision - partial or total, including radical mastectomy and super-radical mastectomy
Stereotactic biopsy

Lymphatic System:

- Excision of lymph node, including radical lymphadenectomy in various regions, i.e., neck, axilla, groin, iliac, retroperitoneum, etc.
Staging laparotomies for lymphoma

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Musculoskeletal and Hand:

- _____ Carpal tunnel surgery
- _____ Excision of ganglions
- _____ Excision of benign and malignant soft tissue tumors
- _____ Extremity amputation
- _____ Incision for hand infections
- _____ Repair extensor tendons

Gastrointestinal, Abdominal and Pelvic Surgery

- _____ Biliary surgery, excluding biliary reconstruction
- _____ Biliary reconstruction
- _____ Colon surgery
- _____ Excision of contiguous organs, part or whole for malignancy, trauma, or infection
- _____ Hepatic surgery
- _____ Laparoscopic procedures
- _____ Pancreatic surgery, including total pancreatectomy
- _____ Rectal surgery
- _____ Splenectomy or repair of spleen
- _____ Surgery of stomach and small intestine

Hernias, Repair of:

- _____ All abdominal wall hernias, including incisional, ventral, inguinal femoral, umbilical, and spigelian diaphragmatic hernias

GU and GYN:

- | | |
|---|--------------------------------------|
| _____ Bartholin cyst | _____ Hysterectomy |
| _____ Cervical biopsy | _____ Orchiopexy/orchioectomy |
| _____ Cystocele/rectocele | _____ Salpingo-oophorectomy |
| _____ Dilation & curettage (D&C) | _____ Soft tissue/tumors of perineum |
| _____ Excision hydrocele and varicocele | _____ Vaginal cyst |

Endocrine Surgery:

- _____ Partial or total excision of thyroid, parathyroid, adrenals, pancreas, and ovaries

Head and Neck:

- _____ Excision of tumors of the neck, including salivary glands, thyroglossal duct cysts, and diverticula
- _____ Neck dissections without pedicle flaps or bone grafts
- _____ Tracheostomy

Thoracic:

- _____ Esophageal surgery
- _____ Thoraco-abdominal procedures
- _____ Thoracoscopic procedures
- _____ Tube thoracostomy

Nerve:

- _____ Sympathectomy, cervical and lumbar
- _____ Vagotomy

Endoscopy with Biopsy:

- _____ Flexible sigmoidoscopy
- _____ Laparoscopy with biopsy

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Vascular:

- _____ Angiography, peripheral
- _____ Aortic abdominal aneurysm
- _____ Endarterectomy and bypass grafting, excluding carotid
- _____ Pacemaker insertion, temporary and permanent
- _____ Vein surgery
- _____ Venous interruption procedures

Miscellaneous:

- _____ Insertion and evaluation of peripheral and central vascular monitoring catheters
 - _____ Pediatric surgery, i.e., hernias, hygromas, cutdowns
 - _____ Respiratory care/management of respirators
 - _____ Surgical consultations within limits of specialty
 - _____ Trauma surgery, including pre- and post-operative
 - _____ *Other: (specify)
-

***Additional procedures require consideration/approval of the Department.**

LEVEL III: Those procedures of a highly-specialized, technically-challenging nature not always included in the curriculum of accredited residency programs in general surgery. Requires a letter of attestation to the candidate's competency in the specific procedure area, including numbers of cases managed in each area. The letter must be from the chairperson or vice chairperson of the candidate's residency program or other documentation/evidence of training and experience, i.e., certificate of course attendance and description of course.

Level III Privileges Requested: All Partial (as checked below)

Vascular Surgery:

- _____ Angioplasty, peripheral
- _____ Carotid artery surgery, all types
- _____ Operations for renovascular hypertension
- _____ Operations for thoracic outlet syndrome

Endoscopy:

- _____ Bronchoscopy with/without biopsy
 - _____ Flexible
 - _____ Rigid
- _____ Colonoscopy with/without polypectomy
- _____ Endoscopic retrograde cholangiopancreatography (ERCP)
- _____ Esophagogastroduodenoscopy

Miscellaneous:

- _____ Advanced neck dissections with pedicle flaps and bone grafts; facial reconstructions, with/without oropharyngeal resection
- _____ Advanced respiratory care, i.e., management of "Jet" ventilators, management of differential pulmonary ventilation, etc.
- _____ Major burn reconstruction

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- _____ Pediatric surgery:
 - _____ Atresias
 - _____ Diaphragmatic hernias
 - _____ Imperforate anus reconstruction
 - _____ Major neonatal abdominal procedures
 - _____ Malrotation
- _____ Primary repair of lacerated peripheral nerves
- _____ Advanced laparoscopic/video-assisted procedures
- _____ Laparoscopic Nissen fundoplication
- _____ Laser surgery
 - _____ Yes*
 - _____ No

*Must complete separate Laser Privilege Request form. (Attached)

_____ *Other: (specify)

***Additional procedures require consideration/approval of the Department.**

Applicant's Signature

Date

For Office Use Only

Recommendations:

- () Approve as requested.
- () Approve with modifications as noted below.
- () Denial of privileges.

Assigned observers:

Modifications:

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Applicant's Name: _____
(Please Print)

I (we) attest that in recommending these privileges, due consideration has been given to the applicant's professional performance, training, experience, judgment, and technical skills.

Chairman, General Surgery Section _____
Date

Chairman, Department of Surgery _____
Date

Co-Chief of Professional Staff (if requesting interim privileges) _____
Date

Action:

Credentials Committee Date: _____

Professional Staff Executive Committee Date: _____

Board of Trustees Date: _____

**McLAREN GREATER LANSING
LASER PRIVILEGE REQUEST FORM**

Applicant's Name: _____
(Please Print)

Specialty: _____

Instructions: Please complete this form and submit it to Medical Staff Services with appropriate documents.

Note: Prior or concurrent approval of the applicable associated clinical procedure(s)/ privilege(s) is a pre-requisite for a favorable recommendation on a request for laser privileges.

Type of laser wavelength available at McLaren Greater Lansing for which you are requesting privileges:

CO₂ Laser

- ____ Endoscopy
- ____ Laparoscopy
- ____ Open surgical
- ____ Arthroscopy

ND: YAG Laser

- ____ Endoscopy
- ____ Laparoscopy
- ____ Open surgical
- ____ Arthroscopy
- ____ Intravascular

ND: YAG Ophthalmic Laser

- ____ Q Switched
- ____ Contact

____ **Holmium YAG Laser**

Pulsed Dye Laser

- ____ Arthroscopy

____ **Excimer Laser**

____ **GreenLight PVP Laser**

Physics and safety lecture attended: _____ Date: _____

Applicant's Signature

Date

For Office Use Only

Recommendations:

- () Approve as requested.
- () Approve with modifications as noted below.
- () Denial of privileges.

Modifications:

I (we) attest that in recommending these privileges, due consideration has been given to the applicant's professional performance, training, experience, judgment, and technical skills.

Chairman, General Surgery Section

Date

Chairman, Department of Surgery

Date

Co-Chief of Staff (if requesting interim privileges)

Date

Action:

Credentials Committee Date: _____
Professional Staff Executive Committee Date: _____
Board of Trustees Date: _____