DEPARTMENT OF SURGERY
PLASTIC AND RECONSTRUCTIVE SURGERY SECTION

Privilege Request Form

Applicant's Name: ____________________________________________________________________

(Please Print)

DIRECTIONS: This Privilege Request Form must accompany all initial applications for appointment to the Plastic/Reconstructive Surgery Section, Department of Surgery. Please indicate those privileges that apply to your surgical practice.

ABDOMINAL SURGERY
_____ Abdominoplasty

NECK SURGERY
_____ Excision of cyst
      ____ Thyroglossal
      ____ Brachial
      ____ Hygroma
      ____ Dermoid
      ____ Incision & drainage of abscess
      ____ Carotid ligation
      ____ Deep node biopsy
      ____ Stellate ganglion block
      ____ Radical dissection
      ____ Salivary gland excision

BREAST SURGERY
_____ Biopsy with frozen section
_____ Mastectomy, simple
_____ Plastic and cosmetic procedures
_____ Reconstructive procedures

THORACIC SURGERY
      ____ Rib resection
      ____ Reconstructive thoracoplasty

CARDIAC & CARDIOVASCULAR SURGERY
_____ Microvascular surgery

EAR SURGERY
_____ Amputation of external ear
_____ Excision of tumor from external ear canal
_____ Otoplasty

EYE SURGERY
_____ Dilatation of lacrimal duct
_____ Probing of lacrimal duct
_____ Operation on tear gland
_____ Reconstruction of orbit & eyelid

ORAL SURGERY
_____ Reduction of jaw fracture
_____ Excision of bone tumor
_____ Plastic repair of mouth and lip
_____ Repair of cleft palate
_____ Gingivectomy

NOSE AND THROAT SURGERY
_____ Nasal bone - reduction of fracture
_____ Nasal septum - submucous resection
_____ Rhinoplasty
_____ Tracheotomy

UROLOGY
_____ Reconstruction of congenital deformity

NEUROSURGERY
_____ Cranioplasty
_____ Nerve resection and transplant
_____ Repair of meningocele
_____ Microsurgical nerve graft

PLASTIC SURGERY
_____ Skin grafting - all types
_____ Bone grafting - all types
_____ Dupuytren's contraction
_____ Repair of epispadias
_____ Syndactylism operation
_____ Pilonidal cyst

MISCELLANEOUS
_____ Hand surgery
_____ Face surgery
_____ Other

___________________________________
___________________________________
Applicant's Signature Date

Page 1 of 2
Applicant's Name: ____________________________________________________________
(Please Print)

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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, Plastic and Reconstructive 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: ______________________________

Comments:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________