DEPARTMENT OF SURGERY
NEUROSURGERY SECTION

Privilege Request Form

Applicant's Name: _____
(Please Print)

In conjunction with my appointment to the Professional Staff, I request the privileges checked below. As consistent with the Credentialing Policy of the Neurosurgery Discipline, I understand that supporting documentation must be provided, as applicable, and that if supporting documentation is not provided, this request will not be considered complete.

_____ Trephination
_____ Craniotomy
_____ Encephalography
_____ Cranioplasty
_____ Intracranial procedures
_____ Nerve resection and transplant
_____ Chordotomy
_____ Repair of meningocele
_____ Rhizotomy
_____ Sympathectomy
_____ Spinal cord operation
_____ Fracture of skull
_____ Fracture of neck
_____ Laminectomy

Other: (Please Specify)

_____

_____

_____ _____
Applicant's Signature *Date*

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DEPARTMENT OF SURGERY
NEUROSURGERY SECTION

Applicant's Name: _____
(Please Print)

For Office Use Only

Department Recommendation:
( ) Approve as requested.
( ) Approve with modifications as noted below.
( ) Denial of privileges.

Modifications_____
_____
_____

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

_____ _____
Chairman, Neurosurgery Section *Date*

_____ _____
Chairman, Department of Surgery *Date*

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

Action:
Credentials Committee Date: _____

Executive Committee Date: _____

Board of Trustees Date: _____

Comments/Modifications Recommended:
_____