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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(Please Print)

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
____ Cervical biopsy
____ Cystocele/rectocele
____ Dilation & curettage (D&C)
____ Excision hydrocele and varicocele
____ Hysterectomy
____ Orchiopexy/orchiopectomy
____ Salpingo-oophorectomy
____ Soft tissue/tumors of perineum
____ 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
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 cholangiopancreatostomy (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:

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________
DEPARTMENT OF SURGERY
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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: ______________________________