

ADVANCED SURGICAL PRIVILEGES FORM / ORTHOPEDIC SURGERY

Applicant's Name:

License No. (If Any): Date: DD MM YY

CATEGORY I: EMERGENCY SURGERY

| Privileges | For applicant use | | For committee use | | |
|---|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| 1. Open reduction with plate/screw fixation (MIPO + LISS) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Use of Hybrid External Fixator (Ilizarov) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Split thickness skin graft (STSG) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

CATEGORY II: PEDIATRIC SURGICAL PROCEDURES

| Privileges | For applicant use | | For committee use | | |
|---|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| A. Pediatric Trauma | | | | | |
| 1. Conservative treatment of pediatric upper limb fractures and injuries | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Surgical treatment of pediatric upper limb fracture and injuries | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Conservative treatment of pediatric Lower limb fracture and injuries | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Surgical treatment of pediatric Lower limb fracture and injuries | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Conservative and surgical treatment of pediatric pelvis and acetabular fracture. | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| B. Pediatric Upper Extremity | | | | | |
| 1. Correction of forearm deformities (e.g. radio ulna synostosis, Madelung's deformity) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| 2. Correction of elbow deformities (e.g. congenital dislocation head of radius, Cubitus Varus) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Correction of shoulder deformities | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Soft tissue/tendon release of the thumb or hand | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Tendon transfer to the elbow, hand or wrist | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Release of congenital trigger fingers in children | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| C. Pediatric Hip Joint | | | | | |
| 1. Ultrasound for diagnosis of DDH (Graf Method) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Arthrography of the hip | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Percutaneous tenotomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Close reduction of the hip and Spica application for DDH | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Extensive soft tissue release of the hip (Neuromuscular disorders) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Open reduction of the hip for DDH | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Proximal femur osteotomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Acetabular osteotomy (Salter, Pemberton...) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Chiari Pelvic osteotomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Triple osteotomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Periacetabular osteotomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Fixation of slipped capital femoral epiphysis (SCFE) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Open surgical hip dislocation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| D. Pediatric Knee Joint | | | | | |
| 1. Manipulation, POP for congenital dislocation of the knee | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Soft tissue release for pediatric dislocation of the knee | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Soft tissue release for fixed flexion deformity (neuromuscular) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Tendon transfer for neuromuscular disorder | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Supracondylar osteotomy of femur | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Osteotomy of the proximal tibia | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Procedures for recurrent dislocation of patella | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Arthroscopy for pediatric knee | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Pediatric ACL reconstruction | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| E. Pediatric Foot and Ankle | | | | | |
| 1. Manipulation and application of POP for clubfoot | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Percutaneous Achilles lengthening | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Posterior release for equinus foot | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Posteromedial release for clubfoot | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Surgical correction of equinus ankle and foot deformity in cerebral palsy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Soft tissue release, open reduction for vertical talus | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Tendon transfer in the foot | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Bony procedures and osteotomy to correct foot deformities | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Extra- articular subtalar fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| 10. Subtalar arthroereisis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Triple arthrodesis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Supramalleolar osteotomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| F. Pediatric Lower Limb | | | | | |
| 1. Epiphysiodesis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Lengthening osteotomy of the femur with motorized nail | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Lengthening osteotomy with TSF or ilizarov frame | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| G. Pediatric Spine | | | | | |
| 1. Fusion of baso-cervical instability | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Treatment of C1/C2 instability | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Surgical treatment of pediatric cervical spine | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Treatment of Sprengel's deformity | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Corpectomy and fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Posterior instrumentation for congenital scoliosis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Posterior and anterior treatment of congenital scoliosis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Instrumentation for juvenile scoliosis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Posterior correction of idiopathic scoliosis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Anterior correction of idiopathic scoliosis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| 11. Instrumentation for neuromuscular scoliosis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Fixation of spondylolisthesis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Lumbar discectomy in selected cases with neurological compromise | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| H. Pediatric Miscellaneous | | | | | |
| 1. Correction of long bone deformities in osteogenesis imperfecta | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Incision and drainage of infected joint (e.g. hip, shoulder, ankle, knee) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Soft tissue biopsy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Bone biopsy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Excision of osteochondroma | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Excision of osteoid osteoma | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Curettage of bone cyst and grafting | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Wide tumor resection and reconstruction (e.g. lesion prosthesis) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Hemipelvectomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

CATEGORY III: UPPER LIMB

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|---------------------------------------|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| A. Shoulder Surgeries | | | | | |
| 1. Shoulder arthroscopy: diagnostic | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Shoulder arthroscopy: slap lesions | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| 3. Subacromial decompression: arthroscopic | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. A/C joint resection: arthroscopic | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Anterior shoulder stabilization procedures: open | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Anterior shoulder stabilization procedures: arthroscopic | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Posterior shoulder stabilization: open | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Hemiarthroplasty shoulder | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Anatomic Shoulder arthroplasty | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Reversed Shoulder replacement | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Revision Shoulder arthroplasty | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Rotator cuff repair: open | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Rotator cuff repair: arthroscopic | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Biceps tendon tenodesis open | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Subscapular nerve entrapment release | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16. Shoulder arthrodesis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 17. Osteotomies around the shoulder | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 18. ORIF of fractures of scapula | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 19. ORIF fracture proximal humerus | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| B. Elbow | | | | | |
| 1. ORIF complex fracture of elbow and distal humerus | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Ligament repair and reconstruction of elbow | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Radial head replacement | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| 4. Elbow joint replacement | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Revision elbow replacement | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Osteotomies around the elbow | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Elbow fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Open soft tissue release around the elbow | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Arthroscopic procedure for the elbow | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| C. Wrist and Hand Surgery | | | | | |
| 1. ORIF complex fracture-dislocation of forearm and wrist | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. ORIF fracture/dislocation of carpal bone, carpo-metacarpal and phalanx | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Surgical treatment for hand and wrist nonunion and malunion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Repair/reconstruction of complex wrist and hand soft tissue and ligament injuries | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Finger replantation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Wrist orthoscopy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. TFCC pathology repair open | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. TFCC pathology repair arthroscopy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Osteotomy of radius and ulna | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Procedure for DRUJ pathology | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Proximal row carpectomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Carpal bone fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Wrist fusion procedure | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| 14. Dupuytren's and soft tissue release of hand | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Small joint replacement | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

CATEGORY IV: PELVIS AND HIP SURGERY

| Privileges | For applicant use | | For committee use | | |
|---|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| 1. Fixation of acetabulum through Kocher Langenbeck approach | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Fixation of acetabulum through Ilioinguinal approach | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Fixation of acetabulum through Stoppa approach | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Fixation of acetabulum through Extended Iliofemoral approach | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Fixation of femoral head | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Fixation of iliac wing/Alis/ASIS fracture | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Hip/SIJ/symphysis pubis aspiration/injection/biopsy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Diagnostic hip arthroscopy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Hip arthroscopic washout and debridement | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Open hip labral repair | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. arthroscopic hip labral repair | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Open femoroacetabular impingement surgery | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Arthroscopic femoroacetabular impingement surgery | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Femoral head microfracture/arthroscopic | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Trochanteric bursectomy/open | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16. Hip tendons injection | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 17. Hamstring tendons/injection/repair | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| 18. Symphysis pubis fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 19. Sacroiliac joint fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 20. Iliac bone grafting | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 21. Girdle stone operation/proximal femoral resection (resection arthroplasty) | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 22. Decompression of entrapment neuropathy around hip and pelvis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 23. Sportsman hernia repair | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 24. Core decompression of proximal femur | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 25. Hip arthrodesis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

CATEGORY V: KNEE SURGERY

| Privileges | For applicant use | | For committee use | | |
|--|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| 1. ORIF complex knee fracture | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. ORIF complex periprosthetic fracture | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Arthroscopic surgery of menisci | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Arthroscopically assisted repair/ reconstruction of anterior cruciate ligaments | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Posterior cruciate ligament repair/reconstruction | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Arthroscopic synovectomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Open repair of collateral ligaments injuries | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Repair of complex ligamentous disruptions | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Operative treatment of patellar instability | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Supracondylar femoral osteotomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. High tibial osteotomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| 12. Arthrodesis of knee | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Total knee arthroplasty | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Unicondylar arthroplasty of knee | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Revision arthroplasty of knee | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

CATEGORY VI: FOOT AND ANKLE

| Privileges | For applicant use | | For committee use | | |
|---|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| 1. ORIF complex foot and ankle fracture / dislocation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Repair / reconstruction of ligament injury of foot and ankle | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Diagnostic / therapeutic ankle arthroscopy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Osteotomy / fusion procedure foot and ankle | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Complex tendon repair or transfer in foot and ankle | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Diabetic foot bone and soft tissue management | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Ilizarov fixation of foot and ankle | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Retrograde calcaneal nail | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Total ankle replacement | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Revision of ankle replacement | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

CATEGORY VII: SPINAL SURGERY

| Privileges | For applicant use | | For committee use | | |
|--|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| 1. Local injections: facet, epidural (caudal), perivertebral | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

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| Privileges | For applicant use | | For committee use | | |
|--|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| 2. Lumbar discectomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Decompressive laminectomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Posterolateral (intratransverse) fusion with or without instrumentation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Transforaminal lumbar interbody fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Oblique lumbar interbody fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Posterior lumbar interbody fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Anterior lumbar interbody fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Corpectomy and anterior fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Correction of spinal deformity with posterior instrumentation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Correction of spinal deformity with anterior instrumentation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Combined anterior and posterior correction of spinal deformity | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Kyphoplasty / vertebroplasty | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Thoracoscopic spinal surgeries | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Minimally-invasive spine surgeries | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16. Kyphectomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 17. Correction of major kyphotic deformity | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 18. Correction of idiopathic scoliosis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 19. Correction of degenerative scoliosis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 20. Anterior cervical discectomy and fusion | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 21. Microscopic discectomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 22. Endoscopic discectomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 23. Cervical laminectomy with or without instrumentation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

ADVANCED SURGICAL PRIVILEGES FORM / ORTHOPEDIC SURGERY

| Privileges | For applicant use | | For committee use | | |
|---|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| 24. Cervical foraminotomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 25. Laminoplasty | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 26. C1-C2 fusion and instrumentation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 27. Cranio-cervical fusion and instrumentation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 28. Cervico-thoracic fusion and instrumentation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

CATEGORY VIII: MISCELLANEOUS

| Privileges | For applicant use | | For committee use | | |
|---|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| 1. Biopsy bone lesion upper or lower extremity including pelvis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Biopsy bone lesion spine | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Biopsy soft tissue lesion upper or lower extremity including pelvis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Biopsy soft tissue lesion trunk / retroperitoneal | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Excision benign bone tumor upper or lower extremity including pelvis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Excision benign bone tumor spine | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Curettage and bone grafting/bone cementing benign bone tumors/cyst, upper and lower extremities including pelvis | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Excision benign soft tissue tumor upper or lower extremity including pelvis with no soft tissue reconstruction | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Van Nes Rotationplasty | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

ADVANCED SURGICAL PRIVILEGES FORM / ORTHOPEDIC SURGERY

CATEGORY IX: AMPUTATIONS

| Privileges | For applicant use | | For committee use | | |
|--|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| A. Upper Extremity | | | | | |
| 1. Amputation of hand, fingers, digits | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Wrist disarticulation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Below elbow amputation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Trans elbow disarticulation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Above elbow amputation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Disarticulation at shoulder | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Forequarter amputation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

| Privileges | For applicant use | | For committee use | | |
|--|--------------------------|-----------|--------------------------|--------------------------|-------------------------------|
| | Request | Signature | Recommended | Not Recommended | Reason for rejection (if any) |
| B. Lower Limb | | | | | |
| 1. Ray amputation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Amputation through metatarsals / tarsal / hind foot | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Ankle disarticulation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Disarticulation of knee | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Above knee amputation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Hip disarticulation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Hemipelvectomy | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Hindquarter amputation | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |

ADVANCED SURGICAL PRIVILEGES FORM / ORTHOPEDIC SURGERY

ADDITIONAL PRIVILEGE (NOT INCLUDED ABOVE)

| Privileges | For applicant use | | For committee use | | | Not Recommended | Reason for rejection (if any) | | |
|------------|-------------------|-----------|-------------------|----------|-----------------|-----------------|-------------------------------|--|--|
| | Request | Signature | Recommended | | | | | | |
| | | | Facility type | | | | | | |
| | | | Hospital | Day care | Clinic under LA | | | | |
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Note:

You must submit along with this application all necessary document(s) to support your request.

Applicant's signature Date: DD MM YYYY

ADVANCED SURGICAL PRIVILEGES FORM / ORTHOPEDIC SURGERY

FOR COMMITTEE USE ONLY

Committee Decision:

Evaluation type:

By Interview virtual / personal

By documents only

Or both

Other comments:

.....

We have reviewed the requested clinical privileges and supporting documentation for the above-named applicant, and We have made the above-noted recommendation(s).

.....

Name, Signature & Stamp

Date: DD MM YYYY

.....

Name, Signature & Stamp

Date: DD MM YYYY

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Name, Signature & Stamp

Date: DD MM YYYY

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Name, Signature & Stamp

Date: DD MM YYYY

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Date: DD MM YYYY

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Name, Signature & Stamp

Date: DD MM YYYY