CORE SURGICAL PRIVILEGES FORM / DERMATOLOGY

Applicant's Name: .....

License No. (If Any): ..... Date: D D M M Y Y Y Y

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. History taking, local skin examination and description of skin lesions with subsequent topical applications description.	☐		☐	☐	
2. Dermojet	☐		☐	☐	
3. Punch Biopsy	☐		☐	☐	
4. Intralesional	☐		☐	☐	
5. Curettage	☐		☐	☐	
6. Comedone extraction	☐		☐	☐	
7. Liquid nitrogen application (cryocautery)	☐		☐	☐	
8. Skin Paring (warts/superficial keratosis /callosity)	☐		☐	☐	
9. Electrocautery	☐		☐	☐	
10. Local Chemical cautery	☐		☐	☐	
11. Removal of sutures	☐		☐	☐	
12. Minor skin surgery (with local anesthesia)	☐		☐	☐	
13. Laser therapy	☐		☐	☐	
14. Chemical peeling	☐		☐	☐	
15. DTM culture (fungus)	☐		☐	☐	
16. KOH scrapings	☐		☐	☐	
17. Methylene blue	☐		☐	☐	
18. Botox injection	☐		☐	☐	
19. Patch test	☐		☐	☐	
20. Wood's light	☐		☐	☐	
21. Crystal peel (Microdermabrasion)	☐		☐	☐	

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Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
22. Dermal Fillers	☐		☐	☐	
23. PRP	☐		☐	☐	

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

Applicant's signature ..... Date: DD MM YYYY

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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).

Clinical privileging committee members:

.....
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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Name, Signature & Stamp

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Name, Signature & Stamp

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