CORE SURGICAL PRIVILEGES FORM / ORTHOPEDIC SURGERY

Applicant's Name: .....

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

CATEGORY I: ADULT EMERGENCY SURGERY (ABOVE 15)

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Application of Traction Pins	☐		☐	☐	
2. Closed manipulation of fractures / dislocations/ splints / casts	☐		☐	☐	
3. Closed manipulation and Percutaneous wire /screw fixation	☐		☐	☐	
4. Open reduction and tension wiring	☐		☐	☐	
5. Open reduction with intramedullary device	☐		☐	☐	
6. Closed reduction with intramedullary device	☐		☐	☐	
7. Open reduction and application of external fixation	☐		☐	☐	
8. Closed reduction and application of external fixation	☐		☐	☐	
9. Operative treatment of simple intra articular fractures	☐		☐	☐	
10. Fasciotomy	☐		☐	☐	
11. Wound debridement	☐		☐	☐	
12. Operative treatment of acute bone, joint & soft tissue infection	☐		☐	☐	
13. Bone grafting	☐		☐	☐	
14. Operative fixation using DHS / DCS / Cannulated screws	☐		☐	☐	

CORE SURGICAL PRIVILEGES FORM / ORTHOPEDIC SURGERY

CATEGORY II: AMPUTATIONS

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
A. Upper Extremity					
1. Amputation of digits	☐		☐	☐	

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
B. Lower Extremity					
1. Below knee amputation	☐		☐	☐	
2. Amputations around ankle	☐		☐	☐	
3. Amputations through tarsus	☐		☐	☐	
4. Ray amputations	☐		☐	☐	
5. Amputations/ terminalizations through phalanges	☐		☐	☐	

CATEGORY III: SHOULDER SURGERY

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Manipulation of frozen shoulders	☐		☐	☐	
2. Subacromial injections	☐		☐	☐	
3. Scapular bursa injection: excision – open	☐		☐	☐	
4. Subacromial decompression: open	☐		☐	☐	
5. A/C joint resection: acromioplasty open	☐		☐	☐	
6. ORIF of fractures/humeral shaft	☐		☐	☐	

CORE SURGICAL PRIVILEGES FORM / ORTHOPEDIC SURGERY

CATEGORY IV: WRIST AND HAND SURGERY

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Tendon repair basic techniques	☐		☐	☐	
2. Nerve entrapment surgery (medial nerve, ulnar nerve)	☐		☐	☐	
3. Surgical treatment of tenosynovitis	☐		☐	☐	
4. Surgical treatment of special hand infections (palmer spaces, web spaces ... etc)	☐		☐	☐	
5. Surgical treatment of tendon sheets infection	☐		☐	☐	
6. Trigger finger, mallet finger, dequarvian (stenosing tenosynovitis)	☐		☐	☐	

CATEGORY V: PELVIS AND HIP SURGERY

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Closed reduction with clamp / fix pelvic ring disruptions	☐		☐	☐	

CATEGORY VI: KNEE SURGERY

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Aspiration of knee	☐		☐	☐	

CORE SURGICAL PRIVILEGES FORM / ORTHOPEDIC SURGERY

CATEGORY VII: FOOT AND ANKLE SURGERY

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Removal, excision of soft tissue swelling and Mortin's neuroma	☐		☐	☐	
2. Surgery for hammer claw and malted toes soft tissue and bony procedure	☐		☐	☐	
3. Tendon repair basic technique	☐		☐	☐	
4. Ingrown toenail operation	☐		☐	☐	
5. Close manipulation of simple extraarticular fracture/ splints and cast	☐		☐	☐	

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

Applicant's signature ..... Date: D D M M Y Y Y Y

CORE 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).

Clinical privileging committee members:

.....
Name, Signature & Stamp

Date: DD MM YYYY

.....
Name, Signature & Stamp

Date: DD MM YYYY

.....
Name, Signature & Stamp

Date: DD MM YYYY

.....
Name, Signature & Stamp

Date: DD MM YYYY

.....
Name, Signature & Stamp

Date: DD MM YYYY

.....
Name, Signature & Stamp

Date: DD MM YYYY

.....
Name, Signature & Stamp

Date: DD MM YYYY

.....
Name, Signature & Stamp

Date: DD MM YYYY