CORE SURGICAL PRIVILEGES FORM / PLASTIC SURGERY

Applicant's Name: .....

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

CATEGORY I: BODY CONTOURING PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Brachioplasty	☐		☐	☐	
2. Breast Surgery:					
a. Augmentation	☐		☐	☐	
b. Mastopexy	☐		☐	☐	
3. Abdominal dermolipectomy	☐		☐	☐	
4. Liposuction:					
a. Arms	☐		☐	☐	
b. Abdomen	☐		☐	☐	
c. Trochanteric	☐		☐	☐	
d. Gluteal region	☐		☐	☐	
e. Thighs	☐		☐	☐	

CATEGORY II: FACIAL AESTHETIC PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Blepharoplasty:					
a. Upper lid	☐		☐	☐	
2. Otoplasty	☐		☐	☐	
3. Simple Rhinoplasty (Tip plasty and alar reduction)	☐		☐	☐	
4. Facial Trauma:					
a. Repair of facial laceration	☐		☐	☐	

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Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
b. Repair of ear laceration	☐		☐	☐	
5. Facial Rejuvenation: *					
a. Chemical peel*	☐		☐	☐	
b. Mechanical peel*	☐		☐	☐	
c. Laser*	☐		☐	☐	
d. Botox injection*	☐		☐	☐	
e. Filler injection*	☐		☐	☐	
f. Thread lift*	☐		☐	☐	
g. Cheiloplasty *	☐		☐	☐	
h. Laser resurfacing of the face *	☐		☐	☐	

CATEGORY III: RECONSTRUCTION

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Burns:					
a. Excision and grafting	☐		☐	☐	
2. Skin reconstruction:					
a. Skin flaps:					
i. Local flaps	☐		☐	☐	
ii. Complex local flaps	☐		☐	☐	
b. Skin grafting	☐		☐	☐	

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CATEGORY IV: OTHERS (NOT INCLUDED ABOVE)

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Hair transplant*	☐		☐	☐	

* Completion of Training course is mandatory.

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

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

CORE SURGICAL PRIVILEGES FORM / PLASTIC 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

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Name, Signature & Stamp

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