Provider Name:

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<th>Privilege</th>
<th>Requested</th>
<th>Deferred</th>
<th>Approved</th>
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Job Description:
Under supervision of the employing physician, the Orthotist designs and fits devices, known as orthoses, to provide care to patients who have disabling conditions of the limbs and spine. Under supervision of the employing physician, the Prosthetist designs and fits devices, known as protheses, for patients who have partial or total absence of a limb.

Qualifications:
1. Completion of an accredited program for the Orthotist and/or Prosthetist.
2. Certification by the American Board of Certification in Orthotics and Prosthetics, Inc


2. Prosthetic Privileges: Measurement, impression taking, model rectification, diagnostic fitting, definitive fitting, postoperative management, external power, and static and dynamic alignment of sockets related to various amputation levels, including partial foot, Symes’, below-knee, above-knee, below-elbow, above-elbow and the various joint disarticulations.

ACKNOWLEDGEMENT OF THE ALLIED HEALTH PROFESSIONAL:
I have requested only those privileges for which I am qualified to perform, based upon my education, training, current experience and demonstrated performance. I understand that in exercising my practice privileges granted, I am constrained by hospital and medical staff policies and rules, including those outlined in the Allied Health Professional Rules and Regulations.

Signature of AHP: ___________________________ Date: ________________

Signature of Supervising Physician: ___________________________ Date: ________________

INTERDISCIPLINARY PRACTICE COMMITTEE RECOMMENDATION:
I have reviewed the requested practice privileges and supportive documentation for the above names applicant and
Huntington Memorial Hospital

Delineation Of Privileges
Orthotics & Prosthetics

Provider Name:

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recommend action on the privileges as noted above.

Applicant may perform practice privileges as indicated: _______ YES _______ NO

Exceptions/Limitations (Please Specify):

________________________________________________________________________________________

________________________________________________________________________________________

APPROVALS

Interdisciplinary Practice Committee: __________________________ Date: _____________

Medical Executive Committee Date: ______________

Board of Directors Date: ________________________