Huntington Hospital

Delineation Of Privileges

Plastic Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

CATEGORY 1 - PLASTIC SURGERY PRIVILEGES:
Criteria: Successful completion of an ACGME or AOA approved Plastic Surgery training program and Board Certification or qualified for certification by the American Board of Plastic Surgery.
Proctoring Requirements: A minimum of six representative cases, in accordance with the Medical Staff Proctoring Protocol.

GENERAL PRIVILEGES:

Admit patients	___	___	___
Consultation Only Privileges	___	___	___
Surgical Assist ONLY	___	___	___
Sedation Analgesia ***Criteria:*** Requires successful completion of the Sedation Assessment test. ***Additional criteria effective April 1, 2015:*** a) Evidence of current ACLS and/or PALS certification from the American Heart Association; AND b) Evidence of completion of an Airway Management Course	___	___	___
a) Adult	___	___	___
b) Pediatric (17 years and under)	___	___	___
Anesthesia (local, regional and nerve)	___	___	___
CATEGORY I - PLASTIC SURGERY PRIVILEGES: Includes the management and coordination of care, treatment and services, including: Medical History and Physical examinations; Consultations; and prescribing medication in accordance with DEA certificate.	___	___	___
Cosmetic Procedures:			
Face lift	___	___	___
Brow lift	___	___	___
Neck lift	___	___	___

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Provider Name:

Privilege	Requested	Deferred	Approved
Blepharoplasty	___	___	___
Rhinoplasty	___	___	___
Septoplasty	___	___	___
Ottoplasty	___	___	___
Lip augmentation	___	___	___
Cheiloplasty	___	___	___
Facial implant	___	___	___
Chemical peel	___	___	___
Dermabrasion	___	___	___
Injectable fillers (fat, etc.)	___	___	___
Hair transplant	___	___	___
Breast augmentation	___	___	___
Breast reduction	___	___	___
Mastopexy	___	___	___
Buttock lift	___	___	___
Thigh lift	___	___	___
Brachioplasty	___	___	___
Abdominoplasty	___	___	___
Panniculectomy	___	___	___

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Privilege	Requested	Deferred	Approved
Body lift	___	___	___
Liposuction	___	___	___
Fat transfer	___	___	___
Alloplastic Implants	___	___	___
Reconstructive Procedures:			
Head and Neck Reconstruction:	___	___	___
Management of facial fractures	___	___	___
Brachial cleft cysts and sinuses	___	___	___
Cleft lip and palate	___	___	___
Mandible reconstruction	___	___	___
Nasal reconstruction	___	___	___
Ear reconstruction	___	___	___
Eye lid reconstruction	___	___	___
Cranioplasty	___	___	___
Tarsorrhaphy/canthopexy/canthoplasty	___	___	___
Parotidectomy	___	___	___
Repair of facial palsy and paralysis	___	___	___
Pharyngoplasty	___	___	___
Radical resection of neoplasms	___	___	___

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Provider Name:

Privilege	Requested	Deferred	Approved
Thyroglossal cyst	___	___	___
Breast Reconstruction:	___	___	___
Breast biopsy	___	___	___
Breast reconstruction:	___	___	___
a) Autologous	___	___	___
b) Implant/Expanders	___	___	___
Nipple reconstruction with flap/graft with implants, both immediate and delayed	___	___	___
Subcutaneous mastectomy with reconstruction	___	___	___
Body Reconstruction:	___	___	___
Abdominal wall, chest wall and thorax reconstruction	___	___	___
Skin and Subcutaneous Tissue Reconstruction:	___	___	___
Lymph node excision	___	___	___
Burns: 1st, 2nd, 3rd treatment	___	___	___
Excision of benign or malignant lesions	___	___	___
Repair of complex lacerations	___	___	___
Free flaps/Microvascular surgery (cutaneous, fasciocutaneous, myocutaneous skin flaps)	___	___	___
Skin grafts, partial and full thickness	___	___	___
Tattoo	___	___	___

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Plastic Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Tissue expansion (non-breast)	___	___	___
Decubitus ulcer surgery	___	___	___
Grafts (includes bone, cartilage, nerve, tendon and synthetic)	___	___	___
Extremity Reconstruction:	___	___	___
Lower extremity reconstruction	___	___	___
Amputations or revisions of amputations	___	___	___
Urogenital Reconstruction:	___	___	___
Urogenital procedures	___	___	___
Hand Procedures:			
Tendon repair/reconstruction	___	___	___
Congenital anomalies (including but not limited to polydactyly and syndactyly, etc.)	___	___	___
Fractures:	___	___	___
a) Hand	___	___	___
b) Wrist	___	___	___
Peripheral nerve repair/nerve graft	___	___	___
Rehabilitative surgery for acquired or congenital deformities	___	___	___
Surgery for ganglia, paronychia, infections, cysts or tumors	___	___	___
Surgery for palmer fasciitis (Dupuytren's)	___	___	___
Amputations or revisions of amputations	___	___	___

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Plastic Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

CATEGORY 2 - PLASTIC SURGERY PRIVILEGES:

Criteria: Applicants must meet the criteria defined for Category I Plastic Surgery privileges; AND, provide documentation of ability to perform the procedures being requested via either certification by a Training Director regarding experience and demonstrated competence, or approved as appropriate by a peer.

Proctoring Requirements: As outlined under each Category 2 privilege below.

CATEGORY 2 - PLASTIC SURGERY PROCEDURES:

Laser Surgery ___ ___ ___

Criteria: Certificate of training is required.

Endoscopic Carpal Tunnel ___ ___ ___

Congenital cranio-facial surgery (excluding cleft lip and cleft palate)

Proctoring Requirements: A minimum of two cases of each procedure requested must be proctored under direct observation.

Competency Requirements: Documentation of performing at least two of each procedure requested within the two-year reappointment period.

Congenital Cranio-Facial Surgery (excluding cleft lip and cleft palate)

a) Cranial vault remodel and related procedures ___ ___ ___

b) Orthognathic surgery ___ ___ ___

Approved: 9/22/2011; 5/22/14; 10/30/2014

ACKNOWLEDGEMENT OF THE PRACTITIONER:

I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at Huntington Hospital, and I understand that: a) in exercising my clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation; b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature of Applicant: _____ Date:_____

Huntington Hospital

Delineation Of Privileges

Plastic Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

DEPARTMENT CHAIR RECOMMENDATIONS

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Applicant may perform privileges and procedures as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

APPROVALS:

Section Chair: _____ Date: _____

Department Chair: _____ Date: _____

Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____