

## Delineation of Privileges

Name: \_\_\_\_\_

### CATEGORY I: CORE PRIVILEGES

Core Privileges/Procedures - GENERAL SURGERY	Requested	Approved
<p>(Note: Please cross out any of the core procedures listed below you do not wish to request. Case listings of procedures performed during residency training will be required at initial application.)</p> <p>1. Work-up, admission, consultation, diagnosis, assessment, and treatment of various conditions, illnesses, and injuries of the alimentary tract, abdomen and its contents, breasts, skin and soft tissue, head and neck, endocrine system, extremity surgery (i.e., biopsy, varicose veins, foreign body removal, skin grafts, etc.), and amputations.</p> <p>2. The comprehensive management of trauma and the complete care of critically ill patients with underlying surgical conditions in the E.D., O.R., and Critical Care Units. This includes procedures associated with critical care management i.e. Swan-Ganz catheter placement; temporary pacemaker insertion; arterial annula placement; endotracheal intubation; central line placement; chest tube insertion; cut down, etc.</p> <p>3. Additional core procedures included are:</p> <ul style="list-style-type: none"> <li>• Laparoscopic procedures such as diagnostic laparoscopy, lap cholecystectomy, lap appendectomy, lap Nissen, GI anastomosis; common bile duct;</li> <li>• Aortoiliac, aortofemoral, and infrainguinal bypass procedures;</li> <li>• Abdominal aortic aneurysm repair and other peripheral aneurysm repair;</li> <li>• Placement of temporary and permanent vascular access such as Groshong, Lifeport, and dialysis access;</li> <li>• Endoscopy: EGD, PEG, flexible sigmoidoscopy, colonoscopy, biopsy with snare polypectomy, needle aspiration of superficial nodes and masses;</li> <li>• Biopsies to include stereotactic breast biopsy, sentinel node biopsy;</li> <li>• Intraoperative sonography;</li> <li>• IV Moderate Sedation.</li> </ul>		

### CATEGORY II: SPECIAL PROCEDURES

Procedures that may not be part of residency/fellowship training and <i>may require proof of additional training or experience. Those procedures below marked with an asterisk (*) have specific credentialing criteria attached.</i>	Requested	Approved
Bariatric Surgery (see credentialing criteria)*		
Non-Cardiac Thoracic Surgery (thoracotomy, bronchoscopy, video-assisted thoracic surgery)		
Laser (Please list):		
Mammatone Breast Biopsy		
Hysterectomy (incidental)		
Advanced Peripheral Vascular Procedures: (see credentialing criteria)*		
1. Diagnostic peripheral angiography		
2. Percutaneous peripheral vascular interventions including angioplasty, stents		
3. Endovascular Aortic Grafting		
4. Carotid Surgery		
Other:		

Name: \_\_\_\_\_

*I hereby certify that I possess the training, skill, experience, and current competency for the clinical privileges I have requested and pledge to practice within the limitations and scope of these privileges.*

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*

**APPROVAL:**

\_\_\_\_\_  
Chief of Surgery

\_\_\_\_\_  
Date