



BAYMEDICAL

Delineation of Privileges

Name: _____

CATEGORY I: CORE PRIVILEGES		
Core Privileges <i>include:</i>	Requested	Approved
Privileges include admission, workup, and the performance of surgical procedures for patients of all ages presenting with both congenital and acquired defects of the body's soft tissue, including the functional and aesthetic management and consultations.		
Breast:	Requested	Approved
Breast surgery including mastectomy, augmentation, reduction, and reconstruction procedures.		
Chest and Abdomen	Requested	Approved
Abdominoplasty including associate abdominal wall hernias, reconstruction of defects of back, reconstruction of deformities of the chest wall.		
Cosmetic Surgery	Requested	Approved
Autologous/Alloplastic facial implant, blepharoplasty, buttock lift, chemical peel, dermabrasion, face lift/rhytidectomy, forehead lift (coronal) hair transplant, lip augmentation, liposuction, otoplasty, rhinoplasty (septoplasty), thigh lift/brachioplasty/abdominoplasty		
Endoscopic Surgery	Requested	Approved
Face lift, forehead lift		
Extremities	Requested	Approved
Acute or delayed reconstructive tendon repair, fractures, hand and wrist, open carpal tunnel release, peripheral nerve repair, nerve graft or neurolysis, reconstructive surgery for acquired or congenital deformities, surgery of ganglia, paronychia, infections, cysts or tumors, surgery of palmar fasciitis or plantar fasciitis (Dupuytren's), traumatic or elective amputation or revisions of amputations, congenital anomalies including but not limited to polydactyly and syndactyly		
Head and Neck	Requested	Approved
Brachial cleft cysts and sinuses, deformities of the jaw, management of facial fractures including but not limited to, open and closed reduction with internal and/or external fixation and bone grafting, oculoplastic surgery including ptosis and duct procedures, parotid gland and other salivary glands, pharyngoplasty, repair of traumatic deformities, thyroglossal cyst, tracheostomy		



Name: _____

Skin, Mucous Membrane, Subcutaneous Tissue	Requested	Approved
Burns, 1 st , 2 nd , 3 rd , including late phases of treatment, dermabrasion, chemical peel and/or debridement of skin, excision of benign or malignant lesions, myocutaneous flap reconstruction, repair of facial palsy and paralysis, muscle grafts/flaps, nerve repairs/graft, facial slings dynamic and static, repair of lacerations and soft tissue defects, skin flaps including, but not limited to adjacent tissue transfer, pedical flaps, myocutaneous flaps, skin grafts, partial and full thickness, tattoo removal, tissue expansion, scar revision, transplantation of autologous, homologous, heterologous or xenologous organs to include harvesting and placement of grafts.		
CATEGORY II: SPECIAL PROCEDURES		
Special privileges <i>which may require additional training/experience:</i>	Requested	Approved
Laser Surgery CO-2 Argon Helium		
Cranio Facial Surgery Repair of facial anomalies including cranial synostosis, and monoblock advancement		
Endoscopic surgery Carpal tunnel release		
Head and Neck Reconstructive or reparative surgery for congenital or acquired deformities including but not restricted to cleft lip and or cleft palate		
Sedation Analgesia (complete separate privilege form)		
Other:		
1.		
2.		
3.		

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:	
_____ <i>Chief of Surgery</i>	_____ <i>Date</i>