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| **NAME:** | Click here to enter text. |

 **DEPARTMENT OF SURGERY**

 **SECTION OF PODIATRY**

 REQUEST FOR SPECIFIC PRIVILEGES

 GROUP 13

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| **1.00** |[ ]  Hammertoe Correction |
| **1.01** |[ ]  Bunion Correction |
| **1.02** |[ ]  Keller Bunionectomy |
| **1.03** |[ ]  Keller Bunionectomy with Implant |
| **1.04** |[ ]  McBride Bunionectomy |
| **1.05** |[ ]  Aiken Bunionectomy |
| **1.06** |[ ]  Wedge Osteotomies of Metatarsals |
| **1.07** |[ ]  Soft Tissue Corrections of Forefoot |
| **1.08** |[ ]  Calcaneal Heel Spur Corrections |
| **1.09** |[ ]  SOFT TISSUE |
| **1.10** |[ ]  Excision of Soft Tissue Mass (Warts, Cyst, Ganglion) |
| **1.11** |[ ]  Nail Repair or Removal, Total or Partial, With or Without Matrixectomy |
| **1.12** |[ ]  Capsulotomy and Tenotomy, all M-P or Interphalangeal Joint |
| **1.13** |[ ]  Tendon Repair |
| **1.14** |[ ]  DIGITAL SURGERY (2-5) |
| **1.15** |[ ]  Digital Arthrodesis |
| **1.16** |[ ]  Digital Arthroplasty (Single or Multiple) |
| **1.17** |[ ]  Partial Ostectomy (2-5) |
| **1.18** |[ ]  Repair of Digital Fracture |
| **1.19** |[ ]  METATARSAL SURGERY |
| **1.20** |[ ]  Excision of Neuroma |
| **1.21** |[ ]  Tibial or Fibular Sesamoidectomy |
| **1.22** |[ ]  PARTIAL OSTECTOMY CALCANEUS |
| **1.23** |[ ]  Heel Spur |
| **1.24** |[ ]  Haglund Deformity |
| **1.25** |[ ]  Partial Ostectomy of Other Tarsals |
| **1.26** |[ ]  Metatarsal Implant (2-5) |
| **1.27** |[ ]  Digital Amputations |
| **1.28** |[ ]  Desyndactylism |
| **1.29** |[ ]  Nerve Decompression, Below Ankle |
| **1.30** |[ ]  Syndactylism of Digits |
| **1.31** |[ ]  Fusion/Arthrodesis of Tarsal/Metatarsal Joints |
| **1.32** |[ ]  OTHER |
| **1.33** |[ ]  Open Reduction/Internal Fixation Fractures of Tarsus and Ankle including Dislocations |
| **1.34** |[ ]  Major Tarsal Arthrodesis-Triple Arthrodesis Ankle Fusion |
| **1.35** |[ ]  Forefoot Amputations |
| **1.36** |[ ]  Skin Grafts, Full Thickness and Split Thickness |
| **1.37** |[ ]  Surgery of Major Malignancy Local |
| **1.38** |[ ]  Reconstruction of Ruptured Achilles Tendon with/without Graft |
| **1.39** |[ ]  Implantable Bone Stimulation/Neuro-Stimulation |
| **1.40** |[ ]   Rotational Flaps and Flap Closure |

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**Department:**

Reviewed and recommended, as requested:\_\_\_\_\_

Reviewed and recommended, with exception:\_\_\_\_\_

Reviewed, but not recommended:\_\_\_\_\_

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# Chairperson Date

**Medical Staff Executive Committee:**

Reviewed and recommended, as requested:\_\_\_\_\_

Reviewed and recommended, with exception:\_\_\_\_\_

Reviewed, but not recommended:\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Board of Hospital Managers:**

Reviewed and approved, as requested:\_\_\_\_\_

Reviewed and approved, with exception:\_\_\_\_\_

Reviewed but not approved:\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: If privileges are denied, limited, or granted other than as requested, documentation must

 be provided.