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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.