

DELINEATION OF PRIVILEGES
 PRACTICE AREA: **HAND SURGERY**

To request these clinical privileges, the following threshold criteria must be met:

1. Licensed by the State of Iowa as M.D. or D.O., **AND**
 - 2a. Board Certification by the American Board of Orthopaedic Surgery or the American Osteopathic Board of Orthopaedic Surgery, **OR**
 - 2b. Successful completion of an ACGME or AOA accredited residency program in Orthopaedic surgery **WITH** board certification in 5 years or less of residency completion.
- OR**
- 2c. Board Certification by the American Board of Surgery or the American Osteopathic Board of Surgery, **OR**
 - 2d. Successful completion of an ACGME or AOA accredited residency program in general surgery **WITH** board certification in 5 years or less of residency completion.
- OR**
- 2e. Board Certification by the American Board of Plastic Surgery or the American Osteopathic Board of Surgery with certification in Plastic and Reconstructive Surgery, **OR**
 - 2f. Successful completion of an ACGME or AOA accredited residency program in plastics **WITH** board certification in 5 years or less of residency completion.
- AND**
- 2g. Completion of a one year fellowship in hand surgery leading to eligibility for the Certificate of Added Qualification in Surgery of the Hand with certification completion within 5 years of fellowship

- AND**
3. Maintain admitting hand surgery privileges at one of the UnityPoint Health-Des Moines Hospitals, one of the Mercy Health-Des Moines Hospitals, VA Central Iowa Health Care System or Broadlawns Medical Center. Surgeons with VA privileges only will be limited to schedule adult patients only at the center.

HAND SURGERY PRIVILEGES - I am requesting hand surgery privileges for:

Requested	Granted	
<input type="checkbox"/>	<input type="checkbox"/>	Examination, consultation, diagnosis and treatment of congenital and acquired defects of the hand and wrist that compromise the function of the hand, and their treatment by surgical methods
<input type="checkbox"/>	<input type="checkbox"/>	Debridement / Excision / Exploration / Revision / Biopsy of soft tissue / bone / cyst / nerve / tumor
<input type="checkbox"/>	<input type="checkbox"/>	Drainage of abscess / hematoma
<input type="checkbox"/>	<input type="checkbox"/>	Injection of Joints
<input type="checkbox"/>	<input type="checkbox"/>	Open & closed reduction / fixation of fractures / dislocations / manipulations / Amputation of digit
<input type="checkbox"/>	<input type="checkbox"/>	Excision of Dupuytren's contracture/ or rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Muscle, tendon, ligament repair, transfer and reconstruction
<input type="checkbox"/>	<input type="checkbox"/>	Nerve Repair / Release / Revision / Transposition / Grafts
<input type="checkbox"/>	<input type="checkbox"/>	Skin Grafts
<input type="checkbox"/>	<input type="checkbox"/>	Arthroscopy / Arthroplasty / Arthrodesis of joints / Total joint replacement of fingers, including implants or Bone grafts
<input type="checkbox"/>	<input type="checkbox"/>	Muscle and tendon Repair / Fixation / Transfers / Reconstruction / Fasciotomy
<input type="checkbox"/>	<input type="checkbox"/>	Endoscopic Carpal Tunnel / Open carpal tunnel
<input type="checkbox"/>	<input type="checkbox"/>	Reconstructive microsurgery (micro vascular flaps and grafts/free tissue transfer, re-implantation and revascularization of the upper extremities and digits, reconstruction of peripheral nerve injury, MOHS micrographic surgery)
<input type="checkbox"/>	<input type="checkbox"/>	Operation, interpretation and reporting of X-ray and C-arm imaging
<input type="checkbox"/>	<input type="checkbox"/>	Administration of local anesthesia
<input type="checkbox"/>	<input type="checkbox"/>	Administration of minimal sedation
<input type="checkbox"/>	<input type="checkbox"/>	Admission to overnight care services
<input type="checkbox"/>	<input type="checkbox"/>	Supervision of Allied Health Practitioner/Residents/Students

To admit patients, perform histories and physicals, order diagnostic tests, request consultations, provide consultations within the scope of your privileges, use all skills normally learned during medical school and residency and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the facility.

You are expected to practice within the bounds of your training and competence and should not attempt to treat cases, which are not in your scope of practice. Newly developed treatment modalities are not included in this request and must be cleared by the Medical Executive Committee and Governing Board before their performance. Please become familiar with the capabilities and limitations of this facility.

I understand that in making this request I am bound by the applicable bylaws and/or policies of Lakeview Surgery Center and hereby stipulate that I meet the threshold criteria for this request. I also certify that I have knowledge to operate all the equipment necessary to carry out requested procedures.

Date

Applicant's Signature

Applicant's Name Printed

Privileges:
 Granted _____ Deferred _____

MEC Signature

Date

Granted _____ Deferred _____

GB Signature

Date

Modifications: _____