DELINEATION OF PRIVILEGES
PRACTICE AREA: **ORTHOPAEDIC 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. **AND**
3. Maintain admitting Orthopaedic privileges at one of the UnityPoint Health-Des Moines Hospitals, one of the Mercy Health Network-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.

ORTHOPAEDIC SURGERY PRIVILEGES - I am requesting orthopaedic surgery privileges for:

Requested	Granted	
□	□	Correct or treat various conditions, illnesses, and injuries to the musculoskeletal system
□	□	Debridement / Excision / Exploration / Revision / Biopsy of soft tissue / bony masses/ cyst / nerve / tumor
□	□	Amputation, digit
□	□	Drainage of abscess / cyst / hematoma
□	□	Injection of Joints – all extremities
□	□	Open & closed reduction / fixation of fractures / dislocations
□	□	Laminectomy / Laminotomy
□	□	Ligament reconstruction
□	□	Manipulation/examination
□	□	Muscle, tendon repair and transfer
□	□	Nerve Repair / Release / Revision / Transposition / Grafts
□	□	Skin Grafts
□	□	Total joint replacement of fingers, toes
□	□	Arthroscopy / Arthroplasty / Arthrodesis of joints, including implants
□	□	Bone grafting
□	□	Muscle and tendon Repair / Fixation / Transfers / Reconstruction / Fasciotomy
□	□	Operation, interpretation and reporting of X-ray and C-arm imaging
□	□	Administration of local anesthesia
□	□	Administration of minimal sedation
□	□	Admission to overnight care services
□	□	Supervision of Allied Health Practitioner/Residents/Students

SPECIAL PROCEDURES/TECHNIQUES

To be eligible to apply for a special procedure listed below, you must meet the above threshold criteria and you **must also** demonstrate successful completion of an approved, recognized course; or acceptable supervised training in residency or fellowship; subspecialty certification; or other acceptable experience and provide documentation of competence in performing that procedure.

Requested	Granted	
□	□	Endoscopic Carpal Tunnel
□	□	Micro-vascular Hand Surgery
□	□	Percutaneous Discectomy
□	□	Hip Arthroscopy

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: _____