THE CENTER FOR ORTHOPAEDIC SURGERY

GENERAL SURGERY, BREAST ONCOLOGY DELINEATION OF PRIVILEGES

Name: _____

The request for Clinical Privileges should be carefully reviewed by the applicant and in accordance with the Medical Staff By-Laws. Only privileges for which documented education and/or training which can be verified will be granted.

Req INITIAL	Description	Medical Director		Anesthesia Director	
	Breast conditions to include biopsy, aspiration, evaluation, and removal				
	Aspiration of breast cyst or abscesses				
	Wounds and conditions of soft tissue, including aspiration, biopsy, and repair				
	Lymph node biopsy or excision				
	Radical axillary dissection				
	Sentinel node biopsy				
	Lumpectomy, quadrantectomy with or without needle localization				
	Modified radical mastectomy				
	Incision and drainage of breast abscesses				
	Terminal central duct incision				
	Subcutaneous Mastectomy				
	Wound debridement				
	C-Arm, use of fluoroscopy and interpretation of image during procedure				
	Ultrasound, use of ultrasound and interpretation of image during procedure				

SIGNATURE PAGE FOLLOWS:

I hereby request the clinical privileges as indicated above. I understand that such privileges include rendering of all associated diagnostic and supportive measures necessary in the performance of privileges I have requested. I understand that any and all privileges granted to me shall be commensurate with my documented training and demonstrated competence, judgment and capabilities. The Medical Advisory Committee and the Executive Board reserve the right to grant or limit my privileges in accordance with my continuing performance in rendering of patient care.

_____ _____

Provider Signature Date

_____ _____

Approval Medical Director/Medical Executive Committee Date

_____ _____

Approval Anesthesia Director/Medical Executive Committee Date