UNION WEST SURGERY CENTER
DELINEATION OF PRIVILEGES
SPECIALTY OF GENERAL SURGERY

I have reviewed the DOP/Roster provided to me by MSS and confirm as indicated below:

- ☐ My DOP is accurate and reflects privileges relevant to my current practice
- ☐ I have listed privileges that should be removed:

_____

_____

Printed Name: _____

Signature: _____

Date: _____

If your roster indicates that you hold any of the privileges listed below, you must provide the maintenance criteria as described, in order to maintain the privilege. Your maintenance criteria and attestation must be returned together.

N/A NO MAINTENANCE REQUIRED

STOP:

UNLESS YOU ARE REQUESTING NEW PRIVILEGES, YOU DO NOT NEED TO GO BEYOND THIS POINT.

Union West Surgery Center
PRIVILEGE REQUEST: GENERAL SURGERY

I would like to be granted privileges to perform the following procedures as indicated by a checkmark:

M.D. _____ Specialty: _____

REQ.	APP.	
_____	_____	Anesthesia: Local
_____	_____	Anesthesia: Topical
_____	_____	Appendectomy, laparoscopic
_____	_____	Axillary node dissection
_____	_____	Breast biopsy
_____	_____	Diagnostic laparoscopy
_____	_____	Excision of nevus/lipoma/sebaceous cyst/lipoma/ skin lesion/mass/suture
_____	_____	Excision/cauterization anal warts
_____	_____	Excision/marsupialization pilonidal cyst
_____	_____	Fistulectomy, fistulotomy
_____	_____	Hemorrhoidectomy
_____	_____	Herniorrhapy, (inguinal, ventral, femoral, umbilical)
_____	_____	History and Physical
_____	_____	Hydrocelectomy
_____	_____	Incision and drainage (I & D) perirectal/perianal abscess
_____	_____	Interpretation of X-rays
_____	_____	Insertion/removal Hickman catheter
_____	_____	Laparoscopic cholecystectomy
_____	_____	Lumpectomy
_____	_____	Muscle biopsy
_____	_____	Node biopsy

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PRIVILEGE REQUEST: GENERAL SURGERY

REQ.	APP.	
_____	_____	Open laparotomy
_____	_____	Removal of catheter (Tenckhoff)
_____	_____	Removal of foreign body
_____	_____	Skin graft, full thickness, split thickness
_____	_____	Sphincterotomy
_____	_____	Supervision of non-physician personnel
_____	_____	Temporal artery biopsy
_____	_____	Toe amputation

_____ _____

Applicant Signature Date