

Applicant Name \_\_\_\_\_

**St. Elizabeth Healthcare**  
**Hand Surgery**

**Minimum Requirements**

Degree required: MD or DO

Successful completion of ACGME or AOA approved residency training program in orthopedic, general or plastic surgery, and either substantial training in surgery of the hand or a hand surgery fellowship

**Note:** Members who first apply for membership after March 2, 2009 must be and remain (with a lapse of no longer than one year) board certified in general, orthopedic or plastic surgery, or become and remain (with a lapse of no longer than one year) board certified within six years of completion of their post-graduate medical training. Only those boards recognized by the American Board of Medical Specialties or the American Osteopathic Association are acceptable. This board certification requirement does not apply to applicants who on March 2, 2009 were members in good standing on the medical staff of the St. Luke Hospitals or St. Elizabeth Medical Center.

**Privileges Requested**

**I. Core Privileges:** Core privileges in hand surgery include the care, treatment or services listed immediately below. I specifically acknowledge that board certification alone does not necessarily qualify me to perform all core privileges or assure competence in all clinical areas. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below. Please line through and initial any specific privileges within a checked privilege group that you are not requesting.

**Request**

**Description of Privilege**

\_\_\_\_\_ Admit patients, perform histories and evaluate, diagnose, treat, and provide consultation to patients of all ages presenting with injuries and disorders of all structures of the upper extremity directly affecting the form and function of the hand and wrist by medical, surgical, and rehabilitative means. Privileges include being able to assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Core privileges in this specialty also include arthroplasty, arthrodesis, and amputation of large and small joints, wrist or hand, including implants; bone grafts pertaining to hand; decompression of peripheral nerves; fasciotomy and fasciectomy; microvascular procedures; local anesthesia and nerve blocks; vascular disorders of hand and forearm; arthroscopy of wrist and small joints; neurolysis, nerve grafts, use of nerve tubes; open and closed reductions of fractures, dislocations, including internal fixation; removal of soft tissue masses, ganglions of palm or wrist, flexor sheath; repair of lacerations; repair of rheumatoid arthritis deformities; skin grafts and flaps; tendon reconstructions and transfers;

tendon releases, repairs, fixations; treatment of complicated infections; burns and frostbite injuries.

\_\_\_\_\_ Moderate Sedation (requires proof of (a) board certification in Anesthesiology, Cardiology, Critical Care, Pulmonology or Emergency Medicine *or* (b) current ACLS Certification *or* (c) satisfactory completion of the ASA Moderate Sedation course).

**II. Additional Privileges:** In addition to the core privileges requested above, I am requesting the additional privileges below. In addition to meeting the minimum requirements for core privileges, applicants must meet all “Additional Requirements” listed for each privilege below and provide documentation (fellowship completion, training course certification, letter from program director or department chair at primary hospital, etc.) demonstrating appropriate education, training, ability and current competence. Credentialing bodies or persons may request additional documentation or information. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below.

<u>Request</u>	<u>Description of Privilege</u>	<u>Additional Requirements</u>
_____	Fluoroscopy-assisted procedures	Radiation Safety certification required.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Printed Name

\_\_\_\_\_ Approved

\_\_\_\_\_ Disapproved

\_\_\_\_\_  
Chair, Section of \_\_\_\_\_

Date:

Remarks: