

**UNIVERSITY OF MARYLAND MEDICAL CENTER**

**Department of Orthopaedics  
Delineation of Privilege Form**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Applicants for membership in the Department of Orthopaedic Surgery of the University of Maryland Medical Center may request admission to the Active staff or the Courtesy staff. **Please indicate the Staff Category to which you wish to apply (refer to Medical Staff Bylaws for qualifications):** \_\_\_\_\_ **Active** \_\_\_\_\_ **Courtesy**

Please check where privileges will be performed:

\_\_\_\_\_ Orthopaedic Clinic    \_\_\_\_\_ University of Maryland Medical Center (UMMC)    \_\_\_\_\_ All Sites

**NOTE: Privileges marked with an asterisk (\*) also require approval of Moderate Sedation privilege (under Section 4)**

Privilege/Operative Procedure	Check (√) if Requested	Chair Approval Initial if Yes Write Not Approved if No
<b>Category 0:</b> In the case of an emergency, any member of the Medical Staff, to the degree permitted by his/her license and regardless of Medical Staff status, service or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. <i>*Approved per the Medical Staff Bylaws</i>	√*	Yes
<b>Category I – Core Privileges:</b> To be eligible for core privileges, applicants must have completed an ACGME approved Orthopaedic Surgery residency program and be Board Certified or a candidate for Board Certification		
<p><b>Outpatient/Ambulatory Services:</b> Practitioners granted core privileges in ambulatory care will provide services to patients in various outpatient clinic settings. The practitioner will routinely interact with patients as the primary care or ambulatory care provider. Services include:</p> <ul style="list-style-type: none"> <li>• General patient examination and care involving observation, assessment, planning, implementation and evaluation.</li> <li>• Ordering, interpreting, and evaluating diagnostic tests to identify and assess patients' clinical problems and health care needs.</li> <li>• Performs preventative health care counseling and instructs patients and/or families on treatment plans.</li> </ul> <p><b>Ambulatory Service locations are as follows:</b></p>		
<p><b>Orthopaedics Clinic:</b> Privileges include ambulatory core privileges as listed above in addition to: debridement: skin and subcutaneous tissue, skin full, skin partial thickness; I&amp;D: abscess simple, hematoma, seroma/fluid, soft tissue abscess, superficial; puncture/aspirations removal of hardware, removal of external hardware</p>		
<b>UMMC Core Privileges</b>		
Arthrocentesis, Arthrotomies, Drainage and Debridement of Osteomyelitis & Septic Arthritis		
Amputations; Release and/or excision of muscle, tendons, fascia, ligaments and nerves		
Arthrodeses, Arthroplastics, Prosthetic or Allograft Replacement of Bones and Joints		
*Bone Biopsies; Excision of Bursae or Calcium Deposits; Excision of Soft Tissue Tumor of Pelvis or Extremities; Excision of Benign and Malignant Bone Tumors; Prophylactic Treatment of Tumors of Appendicular Skeleton; Treatment (Open or Closed) of Impending or Actual Pathologic Dislocations		
*Open or Closed Treatment of Fractures or Dislocations of Extremities or Pelvis (including Skeletal Traction, Internal and External Fixation); Treatment of Open and Closed Soft Tissue Injuries of Extremities and Torso Including But Not Limited to Skin, Muscle, Tendons, Ligaments, Nerves and Vessels; Fasciotomies		
Bone Graft Procedures – Auto and Allografts		
Skin Grafts (Split Thickness, Full Thickness and Pedicle), Rotational Flaps,		
Myocutaneous Flaps		

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Privilege/Operative Procedure	Check ( ✓ ) if Requested	Chair Approval Initial if Yes Write Not Approved if No
Arthroscopy; Knee Arthroscopy (includes Diagnostic Arthroscopy, Meniscus Repair/Resection, Capsular Surgery, Articular Cartilage Repair and Ligament Cartilage Repair), Shoulder Arthroscopy (includes Diagnostic Arthroscopy, Rotator Cuff Repair and Labrum Repair), Hip Arthroscopy, Ankle Arthroscopy and Wrist Arthroscopy		
Lumbar Puncture; Myelograph		
Local Anesthesia		
Tendon Repair, Transfer, Lengthening or Shortening, Peripheral Nerve Repair (simple); Nerve Transposition		
Peripheral Vascular Repair (distal to subclavian artery in upper extremities and distal to external iliac artery in lower extremities) Simple without graft.		
Manipulation of Deformities of Musculoskeletal System, Osteotomy to Correct Deformity		
Fusion of Spine, Anterior Lumbar and/or Thoracic (includes anterior cervical, anterior lumbar/thoracic, posterior cervical, posterior thoracic and posterior lumbar). <b>(For new physicians, substantial experience with each listed procedure during residency/fellowship training must be demonstrated).</b>		
Excision of spinal lesions including disks and tumors; Decompression of canal for stenosis or infection; (Laminectomy: Cervical, Thoracic or Lumbar) Scoliosis and Kyphosis, Surgical Correction with or without Instrumentation (one of the following criteria must be checked ___3cases/2years ___fellowship trained)		
Management or Operative Treatment of Intradural Lesions of the Spine		
Peripheral Nerve Repair – Complex with Graft		
<b>Category II:</b> to be eligible for Category II privileges, applicants must have completed an ACGME approved Orthopaedic Surgery residency program, be Board Certified or a candidate for Board Certification, and provide documentation as to course work and recent experience. <b>Category II privileges are as follows:</b>		
<b>Category III:</b> to be eligible for Category III privileges, applicants must have completed an ACGME approved Orthopaedic Surgery residency program, be Board Certified or a candidate for Board Certification, and have completed the appropriate fellowship and/or training. <b>Category III privileges are as follows:</b>		
Peripheral Vascular Repair – Complex with Graft		
Vascularized Bone Graft, Microvascular Anastomosis for Vascular Bone Graft		
Upper Extremity Microvascular Replantation		
Vascularized Free Flaps		
Orthopaedic Trauma On-Call Schedule <i>*requires approval by Physician In Chief, Program In Trauma</i>		
Orthopaedic Trauma Spine On-Call Schedule <i>*requires approval by Physician In Chief, Program in Trauma</i>		

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Privilege/Operative Procedure	Check ( ✓ ) if Requested	Chair Approval Initial if Yes Write Not Approved if No
<b>Category IV: <u>Special/Cross Disciplinary Procedures:</u></b>		
<b>Moderate (Conscious) Sedation</b> - Criteria for Approval: 1. Proof of Current BCLS certification (please attach); 2. Completion of age-appropriate basic airway management in-service by the UMMC Department of Anesthesia (and every two years thereafter for reappointment). <i>(Physicians board certified in Anesthesiology, Critical Care Medicine, Emergency Medicine, Neonatology, or Oral &amp; Maxillofacial Surgery are not required to fulfill criteria)</i>		
<b>Member of Go-Team</b> – Criteria for Approval (attach verification of each) 1. Valid ATLS Certification 2. Hazardous Materials training attendance 3. Incident Command System training attendance 4. Vehicle Extrication training attendance 5. Maryland EMS Protocols or Base Station Physician Course Training Attendance 6. Go-Team Operations Training Attendance <i>*In order to operate emergency vehicles provided by or funded by the Go-Team, physicians must have completed an approved Emergency Vehicle Operator's Course.</i>		
<b><u>Laser Privileges (separate application required)</u></b>		
Carbon Dioxide		
Argon		
Nd-Yag		
Other:		
<b><u>Ultrasound Procedures (please list)</u></b>		

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Andrew Pollak, MD, Director of Go-Team (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Vincent D. Pellegrini, Jr., MD, Chairman

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Thomas Scalea, MD, Physician-In-Chief, Program In Trauma  
(if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Confirming Signature  
(required if any requested privilege is not approved)  
rev'd 11/07

\_\_\_\_\_  
Date

**UNIVERSITY OF MARYLAND MEDICAL CENTER  
APPLICATION FOR INITIAL PRIVILEGES FOR CLINICAL USE OF LASERS**

NAME: \_\_\_\_\_

DEPT/DIVISION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

For which type of laser are you applying for privileges?

<b>Carbon Dioxide</b> _____ <b>Argon</b> _____ <b>Nd-YAG</b> _____ <b>Other</b> _____
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Approximately how many cases have you done with the laser?

<b>Carbon Dioxide</b> _____ <b>Argon</b> _____ <b>Nd-YAG</b> _____ <b>Other</b> _____
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For what types of surgery do you use the laser? \_\_\_\_\_

\_\_\_\_\_

**Formal courses taken in laser surgery:** Specify title of course, which types of lasers were used, institution where you took the course, date taken, number of hours of hands-on supervised use of the laser, CME credits earned. Enclose copy of CME certificate for the course.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Training with lasers during residency and/or during practice:** Where it occurred, who supervised you, number of cases done with supervision, dates.

\_\_\_\_\_

\_\_\_\_\_

After completing this form, please return it to Medical Staff Services, 110 South Paca Street, 8<sup>th</sup> Floor, Baltimore, MD 21201, or fax it to 410-328-6433.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department/Division Chief

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by Credentials Committee Member

\_\_\_\_\_  
Date

**UNIVERSITY OF MARYLAND MEDICAL CENTER  
APPLICATION FOR RECERTIFICATION FOR CLINICAL USE OF LASERS**

NAME: \_\_\_\_\_

DEPT/DIVISION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

**Current privileges are for the following lasers:**

<b>Carbon Dioxide</b> _____ <b>Argon</b> _____ <b>Nd-YAG</b> _____ <b>Other</b> _____
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*Please list the type of laser and procedures for which you are requesting continued privileges. (Use additional pages if needed for the following information.)*

TYPE OF LASER	PROCEDURES

*List the laser cases which you have done in the past two years:*

TYPE OF LASER	PROCEDURE	NUMBER DONE	NUMBER AND TYPE OF COMPLICATIONS, IF ANY

Since your original certification, have you had any further formal courses in laser surgery? If so, specify title of course, which types of lasers were used, institution where you took the course, date taken, number of hours of hands-on supervised use of the laser, CME credits earned. Enclose copy of CME certificate for the course.

\_\_\_\_\_

\_\_\_\_\_

After completing this form, please return it to Medical Staff Services, 110 South Paca Street, 8<sup>th</sup> Floor, Baltimore, MD 21201, or fax to 410-328-6433.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department/Division Chief

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by Credentials Committee Member

\_\_\_\_\_  
Date