


**AMBULATORY SURGERY DIVISION
REQUEST FOR PRIVILEGES
GENERAL SURGERY**

Name: _____

Date: _____

The minimum education, training and experience qualifications for Medical Staff membership are delineated in the Medical Staff Bylaws, Rules and Regulations and/or Policies and Procedures of each facility. Please consult these documents prior to requesting privileges.

 Indicates privilege is **not** available in this specialty at this facility.

To request privileges, please place an "X" in the appropriate facility column.

Bailey Square Surgery Center	Oakwood Surgery Center	Surgicare of South Austin	North Austin Surgery Center	Description of procedures for which privileges are requested:	Approved	Denied
				Abscess, I & D		
				Basal Cell Carcinoma, Excision		
				Breast Biopsy		
				Chest Tube placement - Emergency		
				Circumcision		
				Cyst, Excision (Ganglion, Sebaceous, Thyroglossal)		
				Excision Pilonidal Cyst		
				Extended Recovery, not to exceed 23 hours		
				Gastric, Lap Banding		
				Granuloma, Excision		
				Gynecomastia, Excision		
				Hemangioma, Excision		
				Herniorrhaphy (Inguinal, Umbilical, & Epigastric)		
				Hydrocelectomy		
				IV Conscious Sedation		
				IV / Injection		
				Keloid, Excision		
				Laparoscopic Cholecystectomy		
				Laparoscopic Herniorrhaphy		
				Lesion, Excision		
				Lipoma, Excision		
				Liver Biopsy		
				Lymphadenopathy, Excision		
				Mass, Excision		
				Mastectomy, Simple		
				Mole Excision		
				Muscle Biopsy		
				Neurofibroma, Excision		
				Nevus, Excision		
				Node, Excision		
				Orchiectomy		
				Orchiopexy		
				Paracentesis		
				Papilloma, Excision		
				Rectal Biopsy		

Bailey Square Surgery Center	Oakwood Surgery Center	Surgicare of South Austin	North Austin Surgery Center	Description of procedures for which privileges are requested:	Approved	Denied
				Removal Foreign Body		
				Scar Revision		
				Skin Biopsy		
				Skin Graft		
				Stereotactic Breast Biopsy		
				Subcutaneous Port - Insertion and Removal		
				Suture Wounds		
				Thyroidectomy, Partial		
				Toenail Removal		
				Undescended Testicle Repair		
				Vein Ligation & Stripping		
				Wart Excision & Fulguration		

___ Laser privileges requested (**Documentation of experience/training required see attached form**)

___ Reads own xray/xray images (**must make note of findings in op report**)

If the condition/privilege you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and/or experience.

In exercising the privileges granted to me, I agree to strictly abide by the facility's Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures. I acknowledge that any restrictions on the clinical privileges granted to me are waived in an emergency/disaster situation, and in such a situation, my clinical privileges will be governed by the facility's Medical Staff Bylaws and Rules and Regulations.

Applicant's Signature & Date

DEPARTMENT RECOMMENDATION

I have reviewed the applicant's credentials and request for the above privileges. The following recommendations are made:

___ APPROVED ___ DENIED ___ DEFERRED ___ OTHER: _____

Department Chairperson's Signature & Date

GOVERNING BOARD APPROVAL

Approval Date per Minutes: ____/____/____
(Privileges expire two years from Approval Date.)