PEDIATRIC NEUROSURGERY PRIVILEGE FORM

NAME:_____ **EFFECTIVE DATE:**_____**To**_____

LEGEND: **1 - Baptist** **2 - Beaches** **3 - Memorial** **4 - Nassau** **5 - Orange Park**
6 - St. Luke's **7 - St. Vincent's** **8 - Shands/Jax** **9 - Specialty** **10 – Wolfson**
11 – Brooks **12 – South**

The minimum education, training and experience qualifications for core privileges are as delineated in each hospital's Medical Staff Bylaws, Rules and Regulations, or policies. Please consult these documents to determine your eligibility to request these privileges.

To request Core Privileges, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	10	11	12	CORE PRIVILEGES	APPR
■	■	■	■		■	■	■	■			■	Admission, assessment, diagnosis, and surgical treatment of pediatric patients presenting with illnesses, injuries and disorders of the central and peripheral nervous system, including their supporting structures and vascular supply. These privileges include the provision of consultation as well as the ordering of diagnostic studies and procedures related to the neurologic problem. These privileges do not include any of the Special Procedures listed separately.	

To request Special Procedures, please place an "X" in the appropriate hospital column. If the condition/privilege you desire is not included on this form, please submit a separate written request along with appropriate documentation of training and/or experience.

1	2	3	4	5	6	7	8	9	10	11	12	SPECIAL PROCEDURES Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training or experience.	APPR
■	■	■	■		■	■	■	■			■	Angiography	
■	■	■	■		■	■	■	■			■	Cordotomy, Rhizotomy	
■	■	■	■		■	■	■	■			■	Deep Sedation **[Hospital 10^{++}]**	
■	■	■	■		■	■	■	■			■	Discography	
■	■	■	■		■	■	■	■			■	Laser Surgery CO2 **[Hospital 10^{++}]**	
■	■	■	■		■	■	■	■			■	Laser Surgery Nd YAG **[Hospital 10^{++}]**	
■	■	■	■		■	■	■	■			■	Lower Back Surgery Involving the use of Various Stabilization Devices **[Hospital 10^{++}]**	
■	■	■	■		■	■	■	■			■	Lumbar Fusion	
■	■	■	■		■	■	■	■			■	Moderate Sedation/Analgesia **[Hospital 10^{++}]**	
■	■	■	■		■	■	■	■			■	Myelography	
■	■	■	■		■	■	■	■			■	Percutaneous Stimulation or Destruction of Spinal Cord	
■	■	■	■		■	■	■	■			■	Stereotactic Surgery	

Acknowledgement of Practitioner: I understand that (a) in exercising clinical privileges granted, I am constrained by each hospital's Medical Staff Policies, rules and regulations, and (b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of each hospital's Medical Staff Bylaws.

Applicant Signature:_____

■ If blacked out, this privilege is not available in this specialty at this hospital.
++ Please refer to this hospital's Bylaws or Rules and Regulations regarding specific criteria to be met before this privilege may be granted.

Edition date – 09/21/2006