PEDIATRIC ORTHOPAEDIC SURGERY 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, and provision of non-surgical and surgical care to pediatric patients to correct or treat various conditions, illnesses, and injuries of the musculoskeletal system.	

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
■	■	■	■	■	■	■	■	■		■	■	Deep Sedation **[Hospital 10^{++}]**	
■	■	■	■	■	■	■	■	■		■	■	Hand Surgery	
■	■	■	■	■	■	■	■	■		■	■	Laser Surgery Argon **[Hospital 10^{++}]**	
■	■	■	■	■	■	■	■	■		■	■	Laser Surgery CO2 **[Hospital 10^{++}]**	
■	■	■	■	■	■	■	■	■		■	■	Laser Surgery Holmium **[Hospital 10^{++}]**	
■	■	■	■	■	■	■	■	■		■	■	Laser Surgery Nd:YAG **[Hospital 10^{++}]**	
■	■	■	■	■	■	■	■	■		■	■	Moderate Sedation/Analgesia **[Hospital 10^{++}]**	
■	■	■	■	■	■	■	■	■		■	■	Peripheral Nerve Surgery	
■	■	■	■	■	■	■	■	■		■	■	Spinal Instrumentation	

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:_____ ***Date:***_____

■ 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.

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