

# PLASTIC SURGERY PRIVILEGE FORM

NAME: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_ To \_\_\_\_\_

**LEGEND:** 1 – BMC - Jax      2 – BMC - Beaches      3 – BMC - Nassau      4 – SV Southside      5 – SV Riverside  
6 – UF Jax/UF TCU      7 – Wolfson      8 – Brooks      9 – BMC - South      10 – SV Clay

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	CORE PRIVILEGES	APPR
										Work-up, admission, assessment, history and physical examination, consultation, surgical and non-surgical treatment of patients with both congenital and acquired defects or deformities of the body's soft tissue. Includes the functional, reconstructive, and aesthetic management of facial and hand fractures. [Physicians desiring privileges for children < 24 months at Wolfson must complete the pediatric plastic surgery privilege form]	

To request Special Procedures, please place an "X" in the appropriate hospital column. 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.

1	2	3	4	5	6	7	8	9	10	SPECIAL PROCEDURES	APPR
										Procedures that may not be part of residency/fellowship training, and/or may require additional proof of training or experience.	
										Hand and wrist endoscopy	
										Hand joint replacement [++Hospitals 4, 5, 6, 10]	
										Laser - CO <sub>2</sub> [++Hospitals 2, 6]	
										Major head and neck oncology surgery [++Hospitals 4, 5, 10]	
										Maxillofacial surgery [++Hospitals 4, 5, 10]	
										Moderate sedation [++Hospitals 1, 2, 3, 4, 5, 6, 7, 9, 10]	
										Plastic surgery endoscopy -- excluding hand [++Hospitals 2, 4, 5, 6, 7, 10]	

**Acknowledgment 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: \_\_\_\_\_

- Privilege 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.