

PODIATRY PRIVILEGE FORM

NAME: _____ EFFECTIVE DATE: _____ To _____

LEGEND: 1 – BMC - Jax 2 – BMC - Beaches 3 – BMC - Nassau 4 – SV Southside 5 – SV Riverside
6 – UF Health/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, diagnosis, history and physical examination, consultation, surgical or non-surgical treatment of the leg below the anterior tibial tuberosity except amputation of the leg or entire foot. Includes ability to admit, write orders and enter appropriate progress notes in the chart. Requires a preoperative note pertinent to podiatry. [Hospital 7 - No admissions]	

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.	
										Achilles Tendon Lengthening [++Hospitals 4, 5, 6, 10]	
										Achilles Tendon Repair [++Hospitals 4, 5, 6, 10]	
										Amputation - including phalanges, but excluding entire foot or leg	
										Application of Cell Therapy (e.g. Apligraph)	
										Arthroplasty of the Ankle [++Hospitals 6]	
										Arthroscopy of the Ankle [++Hospitals 5, 6]	
										Joint Implant	
										Laser – Argon [++Hospitals 1, 9]	
										Laser – CO ₂ [++Hospitals 1, 9]	
										Laser – Holium [++Hospitals 1, 9]	
										Laser - nd:YAG [++Hospitals 1, 9]	

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.