

**DEPARTMENT OF GENERAL SURGERY
DELINEATION OF PRIVILEGES**

NAME OF APPLICANT: _____ DATE: _____

PRIVILEGES REQUESTED		PRIVILEGES GRANTED		PROCEDURE
<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SIMPLE AMPUTATION OF FINGERS, TOES, & TRANSMETATARSAL
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INGUINAL HERNIORRAPHY, INCLUDING LAPAROSCOPIC
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INCISIONAL HERNIORRAPHY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	UMBILICAL HERNIORRAPHY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FEMORAL HERNIORRAPHY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VENTRAL HERNIORRAPHY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BREAST BIOPSY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DEBRIDEMENT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EXCISION AND BIOPSY, MASS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EXCISION OF SUBCUTANEOUS LESIONS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EXCISION OF PILONIDAL CYST
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INCISION & DRAINAGE OF PILONIDAL CYST ABCESS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INCISION & DRAINAGE ABCESS (SUPERFICIAL)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EXCISION OF PLANTAR WARTS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EXCISION OF SKIN LESIONS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FINGER OR TOE NAIL REMOVAL
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FOREIGN BODY REMOVAL
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GANGLIONECTOMY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GYNECOMASTIA EXCISION
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMORRHOIDECTOMY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INCISION & DRAINAGE THROMBOSED HEMORRHOIDS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HYDROCELECTOMY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LAPAROSCOPIC CHOLECYSTECTOMY WITH OR WITHOUT CHOLANGIOGRAM
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPH NODE EXCISION
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PORTA CATH INSERTION AND REMOVAL
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EXPLORATORY LAPAROSCOPY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	REPAIR OF LACERATIONS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	REPAIR OF EPIGASTRIC HERNIA
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RECTAL BIOPSY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RECTAL DILATATION
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	REMOVAL OF SUTURE GRANULOMA
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AXILLARY NODE DISSECTION
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SKIN GRAFTING
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SIMPLE MASTECTOMY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	UMBILICAL SINUS EXCISION
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VARICOCELECTOMY

(GENERAL SURGERY PRIVS CONT'D)

PRIVILEGES REQUESTED PRIVILEGES GRANTED

<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>PROCEDURE</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VARICOSE VEIN LIGATION W/ OR W/OUT STRIPPING
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RECTAL OR ANAL FISTULECTOMY OR FISTULATOMY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ANAL FISSURECTOMY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SKIN AND/OR MUSCLE BIOPSY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TEMPORAL ARTERY BIOPSY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MANIPULATION UNDER ANESTHESIA (MUA)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

SIGNATURE OF APPLICANT: _____ DATE: _____

SIGNATURE OF REVIEWING PHYSICIAN: _____ DATE: _____

SIGNATURE OF MEDICAL DIRECTOR: _____ DATE: _____

Physician Job Description

Reports To: Medical Director and Board of Directors

Position Summary: The Surgeon should be a highly visible, working physician representing the Center to the medical community and the public.

The Physician should participate in and understand the centers budget. He/she should work in a collegiate way with the Administrator and the Nurse Manager to affect efficient and profitable operations.

Qualifications:

A Physician shall be a physician who has successfully completed a residency program Accredited by the Accreditation Council for Graduate Medical Education or Approved by the American Osteopathic, or successfully achieved Podiatry Licensure. Member of the Medical Staff as a licensed independent practitioner, with active clinical privileges appropriate to the Center. Keeps abreast of national and federal regulations.

Responsibilities:

1. Participates in orientation and educational activities.
2. Participates in staff orientation and staff educational activities.
3. Assures quality care is rendered in the Center.

Work Environment and Hazards:

Hazards include risk of exposure to communicable diseases and hazardous substances, and the risk of physical injury from moving/ lifting patients and equipment, as well as operation of equipment. Work may be stressful at times. Interaction with others is constant and interruptive. Contact may involve with dealing with sick/and or persons under high stress/anxiety. While occasionally exposed to fumes or airborne particles and or toxic or caustic chemicals. The noise level in the work environment is usually moderate.

Special Physical Demands: The physical demands described here are representative of those that may be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to stand, use hands, talk and hear. The employee must occasionally climb, stoop, or balance; kneel, sit, walk, use hands to finger, handle or feel objects, tool or controls; and reach with hands and arms. The employee must occasionally lift and/or move fifty (50) pounds and occasionally lift/move more than one hundred (100) pounds. Specific vision abilities required by this job include close vision, distance vision, peripheral vision, and the ability to adjust to focus

The above statements reflect the general outline considered necessary to describe the principal functions of this job. It shall not be construed as a detailed description of all work requirements of the job.

Signature

Date _____