**DELINEATION OF PRIVILEGES**

**CHIROPRACTOR/MANIPULATION UNDER ANESTHESIA**

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CATEGORY:** Provisional Active Reappointment Initial Appointment

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Code** | **Title** | **\*Requested** | **Approved** | **Observation** | **Denied** |
| MUA1 | MUA of Pelvis |  |  |  |  |
| MUA2 | MUA of Hip, Joints |  |  |  |  |
| MUA3 | MUA of any area of Spine |  |  |  |  |
| MUA4 | MUA of Shoulder, Joints |  |  |  |  |
| MUA5 | MUA of Elbow, Joints |  |  |  |  |
| MUA6 | MUA of Knee, Joints |  |  |  |  |
| MUA7 | MUA of Ankle, Joints |  |  |  |  |
| MUA8 | MUA of Wrist, Joints |  |  |  |  |
| MUA9 | MUA of Finger, Joints  |  |  |  |  |
| MUA10 | MUA of TMJ |  |  |  |  |

**I attest that I am appropriately trained, qualified, capable and comfortable to perform all procedures for which I have requested privileges:**

 **Have you had any complications before doing the above privileges? Yes \_\_\_\_\_ No \_\_\_\_\_\_**

 **If Yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 **Date Applicant Signature**

**RECOMMENDATION:**

I have reviewed the applicant's request for Chiropractor Services and recommend that the requested privileges be approved and granted.

\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date Chief of Services Signature

\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date Medical Director Signature