THE CENTER FOR ORTHOPAEDIC SURGERY

DELINEATION OF PRIVILEGES

GENERAL SURGERY, BREAST ONCOLOGY

Name: _____

The request for Clinical Privileges should be carefully reviewed by the applicant and in accordance with the Medical Staff By-Laws. Only privileges for which documented education and/or training which can be verified will be granted.

Description	Requested	Not Requested
Breast conditions to include biopsy, aspiration, evaluation, and removal		
Aspiration of breast cyst or abscesses		
Wounds and conditions of soft tissue, including aspiration, biopsy, and repair		
Lymph node biopsy or excision		
Radical axillary dissection		
Sentinel node biopsy		
Lumpectomy, quadrantectomy with or without needle localization		
Modified radical mastectomy		
Incision and drainage of breast abscesses		
Terminal central duct incision		
Subcutaneous Mastectomy		
Wound debridement		
C-Arm, use of fluoroscopy and interpretation of image during procedure		
Ultrasound, use of ultrasound and interpretation of image during procedure		

I hereby request the clinical privileges as indicated above. I understand that such privileges include rendering of all associated diagnostic and supportive measures necessary in the performance of privileges I have requested. I understand that any and all privileges granted to me shall be commensurate with my documented training and demonstrated competence, judgment and capabilities. The Medical Advisory Committee and the Executive Board reserve the right to grant or limit my privileges in accordance with my continuing performance in rendering of patient care.

_____ _____

Signature Date