FLOYD MEDICAL CENTER

Dermatologic Surgery

I,_____________________________, MD, do hereby apply for the following privileges in Dermatologic Surgery in the Department of Surgery.

Please check all privileges desired. All privileges are first approved by the Department of Surgery and Executive Committee. Final approval is granted by the governing board.

PRIVILEGE	REQUESTED	APPROVED
Routine biopsy or excision relating to a dermatological problem		
Hair transplants		
Pinch, split, and full thickness grafts		
Lip wedges		
Lip shaves		
Dermabrasion		
Rotation of skin flaps for closure wounds from excision of lesions (excludes muscle or mycutaneous flaps; face, forehead, or neck lifts; or extensive reconstructive surgery		

Acknowledgement of practitioner

1. I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform, and that I wish to exercise at Floyd Medical Center, and I understand that:
2. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
3. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.
4. All members of the medical staff are required to treat patients, their families, hospital staff, and colleagues in a respectful and professional manner at all times. Each member of the medical staff is expected to comply with hospital and medical staff code of conduct policies. Failure to do so may be the basis for dismissal.

___________________________________ ______________________

Applicant's Signature Date

APPROVED:

___________________________________ ______________________

Department Chairman Date

EXECUTIVE COMMITTEE RECOMMENDATION

______Concur with Department's recommendation and forward to governing body

______Return to Department for clarification of the following:

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Date_________________

GOVERNING BODY APPROVAL _________*Yes* ________*No*

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Date