Regions Hospital
Delineation of Privileges
Foot and Ankle Surgery / Podiatry

Applicant's Name: ____________________________________________________________________________

Last   First         M.

Instructions:
• Place a check-mark where indicated for each core group you are requesting.
• Review education and basic formal training requirements to make sure you meet them.
• Review documentation and experience requirements and be prepared to prove them.
  ✓ Note all renewing applicants are required to provide evidence of their current ability to perform
    the privileges being requested.
  ✓ When documentation of cases or procedures is required, attach said case/procedure logs to this
    privileges-request form.
• Provide complete and accurate names and addresses where requested -- it will greatly assist how
  quickly our credentialing-specialist can process your requests.

Overview
Core I    –  general privileges in podiatry
Core II   –  forefoot and simple rearfoot surgery
Core III  –  rearfoot and ankle surgery
Special privileges
  arthroscopy
  endoscopic procedures
  extra corporeal shock wave therapy
  ankle replacement
  laser

Core procedure list
Signature page
### CORE I — General privileges in podiatry

<table>
<thead>
<tr>
<th>Privileges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit, evaluate, diagnose, provide non-surgical and surgical care to patients of all ages presenting with injuries and disorders of the foot and ankle including soft tissues below the tibial tuberosity. Surgical privileges include nail and soft tissue procedures.</td>
</tr>
<tr>
<td>The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.</td>
</tr>
</tbody>
</table>

### Basic education and minimal formal training

1. DPM
2. Current board certification or active participation in the examination process -- with achievement of certification within 7 years following completion of all postgraduate training -- leading to certification by the American Board of Foot & Ankle Surgery or the American Board of Podiatric Orthopaedics / Primary Podiatric Medicine.

### Required documentation and experience

**NEW APPLICANTS:**
1. Provide contact information for two physician peer whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

| Name: ____________________________ | Name: ____________________________ |
| Name of Facility: ___________________ | Name of Facility: ___________________ |
| Address: ___________________________ | Address: ___________________________ |
| Phone: ___________________ Fax: ______________ | Phone: ___________________ Fax: ______________ |
| Email: ____________________________ | Email: ____________________________ |

**REAPPPOINTMENT APPLICANTS:**
1. Provide contact information for a physician peer whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

| Name: ____________________________ |
| Name of Facility: ___________________ |
| Address: ___________________________ |
| Phone: ___________________ Fax: ______________ |
| Email: ____________________________ |
### CORE II — Forefoot and simple rearfoot surgery

#### Privileges
Forefoot reconstructive procedures, fracture care of the phalanges and metatarsals and simple rearfoot procedures.

#### Basic education and minimal formal training
1. DPM
2. Successful completion of an approved Podiatric Surgical or Podiatric Medicine and Surgical residency;  
   **Or**
   Successful completion of an approved Rotating Podiatric Residency or Podiatric Orthopedic Residency with documentation of formal training and experience.
3. Current board certification or active participation in the examination process -- with achievement of certification within 7 years following completion of all postgraduate training -- leading to certification by the American Board of Foot & Ankle Surgery or the American Board of Podiatric Medicine.

#### Required documentation and experience

**NEW APPLICANTS:**
1. Must hold Core I privileges  
2. Provide contact information for two physician peers whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
<th>Name: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Facility: ____________________________</td>
<td>Name of Facility: ____________________________</td>
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<tr>
<td>Address: ____________________________</td>
<td>Address: ____________________________</td>
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<tr>
<td>Phone: ___________ Fax: ___________</td>
<td>Phone: ___________ Fax: ___________</td>
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<tr>
<td>Email: ____________________________</td>
<td>Email: ____________________________</td>
</tr>
</tbody>
</table>

**REAPPOINTMENT APPLICANTS:**
1. Must hold Core I privileges.  
2. Provide contact information for a physician peer whom the credentialing specialist may contact to provide an evaluation of your competency.

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
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<tbody>
<tr>
<td>Name of Facility: ____________________________</td>
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<tr>
<td>Address: ____________________________</td>
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<tr>
<td>Phone: ___________ Fax: ___________</td>
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<tr>
<td>Email: ____________________________</td>
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</tbody>
</table>
CORE III — Rearfoot and ankle surgery

### Privileges
Surgical privileges include rearfoot and ankle reconstructive procedures including orthodesis and fracture care.

### Basic education and minimal formal training
1. DPM
2. Successful completion of an approved 24 month Podiatric Surgical residency or greater or 36 month Podiatric Medicine and Surgical residency
   *Or*
   Successful completion of an approved 12 month Podiatric Surgical Residency, 24 month Podiatric Medicine & Surgical Residency, Podiatric Orthopaedic residency, Rotating Podiatric Residency with documentation of formal training and experience.
3. Current board certification or active participation in the examination process -- with achievement of certification within 7 years following completion of all postgraduate training -- leading to certification by the American Board of Foot & Ankle Surgery or the American Board of Podiatric Medicine.

### Required documentation and experience

**NEW APPLICANTS:**
1. Must hold Core I and II privileges.
2. Provide contact information for two physician peers whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

<table>
<thead>
<tr>
<th>Name</th>
<th>Name of Facility</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
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**REAPPOINTMENT APPLICANTS:**
1. Must hold Core I and Core II privileges
2. Provide contact information for a physician peer whom the credentialing specialist may contact to provide an evaluation of your competency.

<table>
<thead>
<tr>
<th>Name</th>
<th>Name of Facility</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
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</thead>
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## Special privileges in foot & ankle surgery (continued)

<table>
<thead>
<tr>
<th>Privilege</th>
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<tbody>
<tr>
<td>Indicate selections with an “X”</td>
</tr>
<tr>
<td>Arthroscopy</td>
</tr>
<tr>
<td>Endoscopic procedures</td>
</tr>
<tr>
<td>Extra corporeal shock wave therapy</td>
</tr>
<tr>
<td>Ankle replacement</td>
</tr>
<tr>
<td>Laser (type: ______________________)</td>
</tr>
</tbody>
</table>

### Basic education and minimal formal training

1. Hold one of the core privileges
2. Certificate of training in special privilege requested

### Required documentation and experience

**NEW APPLICANTS:**
1. Provide certificate of training in special privileges requested
2. Provide documentation of clinical activity involving the privilege requested in the prior 12 months.
3. Provide contact information for a physician peer whom the credentialing specialist may contact to provide an evaluation of your competency.
   - Name: ______________________________________________________
   - Name of Facility: ___________________________________________
   - Address: __________________________________________________
   - Phone: ________________________ Fax: _______________________
   - Email: ____________________________________________________

**REAPPOINTMENT APPLICANTS:**
1. Provide documentation of clinical activity involving the privilege requested in the prior 12 months.
   **Or**
   Provide contact information for a physician peer whom the credentialing specialist may contact to provide an evaluation of your clinical competency.
   - Name: ______________________________________________________
   - Name of Facility: ___________________________________________
   - Address: __________________________________________________
   - Phone: ________________________ Fax: _______________________
   - Email: ____________________________________________________
Core Procedure List — Foot and Ankle Surgery

To the applicant: Strike though procedures you do not wish to request.

This list is a sample of procedures included in the cores. It is not intended to be all-encompassing but reflective of the categories/types of procedures included in the cores.

Core I – general podiatry
1. Nail procedures
2. Soft tissue procedures
3. Wound debridement
4. Incision and drainage

Core II – forefoot and simple rearfoot surgery
1. Partial foot amputation
2. Forefoot reconstruction including fusion and osteotomy
3. Fracture and dislocation care of the phalanges and metatarsals
4. Haglunds resection
5. Rearfoot bone spur removal
6. Flap surgery
7. Bone graft
8. Mass excision
9. F.asciotomy

Core III – rearfoot and ankle surgery
1. Arthrodesis
2. Fracture care
3. Osteotomy
4. Rearfoot amputation
5. Tendon repair and transfer
6. Bone graft
7. Treatment of cartilage injuries

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which – by education training, current experience and demonstrated performance – I am qualified to perform and that I wish to exercise at Regions Hospital. I understand that:

1. In exercising any clinical privilege granted, I am governed by Regions Hospital and Regions Medical Staff policies and rules applicable generally and any applicable to the particular situation.
2. In an emergent situation I may perform a procedure for which I am not privileged when no practitioner holding the applicable procedure is available to respond to the emergency.

I agree to supply Regions Hospital Medical Staff Services (or designee) with all the information that has been requested of me for the privileges that I have applied for. I also understand that my application for privileges will not proceed until the information is received.

__________________________________________________
Signature

__________________________________________________
Date