Cosmetic Surgery Privileges
Department of Surgery – Special Consideration
(Consult Only)*

Name: ____
(Please print)

_____ Initial privileges (initial appointment)
_____ Renewal of privileges *(reappointment, on 2-year specialty cycles)*
_____ Modification of privileges *(request for any additional privileges beyond those previously granted)*

* Special Consideration privileges do not constitute full medical staff privileges and care must be provided in tandem with a member of the Active Medical Staff.

Basic Education: MD or DO

Minimal formal training: Successful completion of an ACGME or AOA accredited residency in a surgical specialty, and current certification or active participation in the examination process (with achievement of certification within 5 years of training completion) in cosmetic surgery.

Required current experience: Performance of at least 100 cosmetic surgery procedures in the last 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

BLS at a minimum is required.

Facility (Check ALL that are applicable to your request)				
Baroness*	Children's**	North	East	Bledsoe/Sequatchie

** Includes BEH Main Hospital, Miller Eye Center, Plaza Surgery and all Erlanger Ambulatory Clinics*
***Includes Children's Hospital Inpatient, Children's Ambulatory clinics, Children's OR and Kennedy Children's Outpatient Center*

<u>Core Cosmetic Surgery Privileges:</u>

Core privileges for cosmetic surgery include the ability to evaluate, diagnose, and provide consultation to admitting physicians caring for patients of all ages.

Physicians may **not** admit patients to the hospital or provide care to patients in the intensive care setting.

Request for Privilege Not Listed in Core or Special Non-Core *(please list the privilege and provide justification as well as any accompanying certifications or case logs)*

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Department Chief Recommendation:

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant.

________ Recommended as Requested

________ Recommended with Modifications (See comments below)

________ Not Recommended (See comments below)

Chief Comments: ____

____ ____________________

Provider Signature Date

____ ____________________

Chief Signature Date

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