# Suffolk Surgery Center

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(631) 205-9090 • Fax (631) 205-9257

## Delineation of Privileges
## General Surgery

Please indicate by a check in the requested column those privileges that are commensurate with your clinical ability, training and experience for which you are applying.

| Requested Privileges | FOR OFFICE USE ONLY Approved | Denied |
|---|---|---|
| **SKIN, SUBCUTANEOUS, AND SUPERFICIAL SURGERY** | | |
| ☐ I & D Abscess, any location | | |
| ☐ Suture of laceration—all | | |
| ☐ Biopsy of Lesions, including lymph nodes | | |
| ☐ Excision of lesions, including pinonidal cysts, lymph nodes | | |
| ☐ Skin grafts, split and full thickness | | |
| ☐ All Hemorrhoid surgery | | |
| ☐ External Anorectal surgery | | |
| **HEAD AND NECK** | | |
| ☐ Skin and subcutaneous, including lips | | |
| ☐ Excision—all lesions | | |
| ☐ I&D | | |
| ☐ Intraoral—All Surgery | | |
| ☐ Tongue | | |
| ☐ Gingiva | | |
| ☐ Cheek | | |
| ☐ Thyroglossal Cysts | | |
| ☐ Lymph Nodes Excision & Biopsy | | |
| **BREAST** | | |
| ☐ Excisional | | |
| ☐ Lumpectomy | | |
| ☐ Axillary Node Dissection | | |
| ☐ Simple Mastectomy | | |
| ☐ I&D | | |
| **THORACIC** | | |
| ☐ Tracheostomy | | |
| ☐ Chest Wall Biopsy | | |
| ☐ Revision of Tracheostomy | | |
| ☐ Insertion of Chest Tube | | |

*(Next Page)*

| Requested Privileges | FOR OFFICE USE ONLY Approved | Denied |
|---|---|---|
| **VENOUS** | | |
| ☐ Ligation and Stripping | | |
| ☐ Minor Arterial Vascular Procedures | | |
| ☐ lntraveous Access Device | | |
| ☐ Temporal Artery Biopsy | | |
| **ENDOSCOPY** | | |
| ☐ Colonoscopy | | |
| ☐ Sigmoidoscopy | | |
| ☐ Laparoscopy | | |
| ☐ Hernia Repair | | |
| **ORTHOPEDICS** (only as part of a general surgery procedure) | | |
| ☐ Minor amputations | | |
| ☐ Ganglion | | |
| ☐ Carpal Tunnel | | |
| ☐ **OTHER** | | |

I, _____

hereby request privileges in the specialty of General Surgery as indicated. I understand that privileges requested may differ from those approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

_____ _____

**Physician (Signature)** **Date**

## APPROVAL

FOR OFFICE USE ONLY

My recommendation in regard to clinical privileges and membership is based on review and evaluation of relevant verified education, training or experience, current licensure, current competence and the applicant's ability to exercise clinical privileges requested.

☐ Qualified to receive Medical Staff membership and clinical privileges as requested.

☐ Qualified to receive Medical Staff membership and clinical privileges with changes noted:

_____

☐ Not qualified to receive Medical Staff membership and clinical privileges as requested:

_____

_____ _____

**Medical Director** **Date**