

**Harris Methodist Southlake
Center for Diagnostics and Surgery**

Core Privileges in Plastic Surgery

Name: _____

Please indicate with a check mark the privileges requested.

Qualifications

To be eligible for core privileges in plastic surgery, the applicant must meet the following qualifications:

- Demonstration of the performance of at least 100 plastic surgery procedures in the past two years, or successful completion of a hospital-affiliated formalized residency or clinical fellowship in the past two years;
and
- Current certification or eligibility to participate in the examination process leading to certification in plastic and/or reconstructive surgery by the American Board of Plastic Surgery or the American Osteopathic Board of Surgery;
and
- Successful completion of an ACGME- or AOA-accredited residency in plastic and reconstructive surgery.

_____ **Group 1: Breast Core Privileges**

Privileges to admit, evaluate, diagnose, and perform surgical procedures related to the breast, for male and female patients of all ages—except as specifically excluded from practice and except for those special procedure privileges listed below. Core privileges include, but are not limited to tissue expander reconstruction, implants, TRAM flaps, biopsies, and augmentation.

Plastic Surgery on the female and male breast, including but not limited to:

- Tissue expander reconstruction
- Pedicle TRAM flaps
- Latissimus dorsi muscle flap
- Breast augmentation
- Breast reduction
- Breast lift (Mastopexy)
- Saline implants
- Silicone gel implant/silicone gel protocol
- Breast biopsies
- Secondary breast revision, including periprosthetic capsulectomy

_____ **Group 2. Aesthetic and cosmetic core privileges**

Privileges to admit, evaluate, diagnose, and perform surgical procedures related to the head, neck, trunk, and extremities for patients of all ages—except as specifically excluded from practice and except for those special procedure privileges listed below. Core privileges include but are not limited to liposuction (with or without ultrasonic assistance), face/neck lift, eyelid surgery, ear surgery, trunk abdominoplasty, breast augmentation, brow lift (with or without endoscopic assistance), hair transplant, and injections for contour restorations, scar revision, and aging skin.

Aesthetic/Cosmetic surgery of the head, neck, trunk and extremities, including but not limited to:

- Liposuction – head, neck, trunk and extremity

- Facial cosmetic surgery
- Face lift/neck lift
- Brow lift
- Cheek lift
- Eyelid surgery
- Nasal surgery including septum, turbinates, and nasal fractures (Chronic and Acute)
- Ear surgery
- Trunk abdominoplasty
- Trunk lift
- Lifts to the extremities
- Chemical Peel
- Laser resurfacing
- Breast augmentation
- Hair implantation
- Injection procedures for contour restorations, scar revision and aging skin including, but not limited to: Fat injections, Botox injections, Collagen injections and Restylane

_____ Group 3. Hand Surgery and Lower Extremity Surgery Core Privileges

Privileges to admit, evaluate, diagnose, and perform surgical procedures related to the hand and lower extremities for patients of all ages—except as specifically excluded from practice and except for those special procedure privileges listed below. Core privileges include but are not limited to release of soft tissue scar and revision, tendon repair, nerve grafting, tunnel releases, bone fixation of hand fractures distal to the carpal row, and cancer excision/reconstruction.

_____ Group 4. Skin Lesions/Trauma Core Privileges

Privileges to admit, evaluate, diagnose, and perform surgical procedures for patients of all ages—except as specifically excluded from practice and except for those special procedure privileges listed below. Core privileges include but are not limited to tumors of the skin and intra-oral cavity, treatment and closure of traumatic wounds with primary closure, grafts, and flaps, burn care for patients with minimum burns.

Special procedures privileges

To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure, within the last 2 years consistent with the criteria set forth here.

Procedure	Criteria	Requested	Recommended	Not Recommended
Microvascular tissue transfer free flaps with microvascular privileges:				
- Digit replantation	6 cases			
- Breast reconstruction with microvascular free flaps	6 cases			
- Extremity, trunk, head and neck reconstruction with microvascular free flaps	6 cases			

Extremity surgery, specialty hand surgery, bone fixation, carpal row and proximal including, but not limited to: scaphoid reconstruction, carpal bone reconstruction, radius and ulnar reconstruction with fixation devices	6 cases			
Congenital anomalies:				
- Cleft lip and palate primary and secondary reconstruction	6 cases			
- Reconstruction congenital deformities of the hands, including, but not limited to syndactyly, polydactyly	6 cases			
Maxillofacial soft tissue and bone trauma:				
- Pediatric craniofacial reconstruction	6 cases			
- Maxillofacial fractures and frontal sinus fractures reconstruction with plates and /or bone grafting	6 cases			
- Facial nerve reconstruction including harvesting of nerve grafts	6 cases			
- Parotid tumor, benign and malignant, excision and reconstruction	6 cases			
Decubitus ulcers: Debridement/reconstruction with flaps, grafts	6 cases			

Recommended/Not recommended with the following modification(s) and reason(s):

****If the procedure that you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and experience.**

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 **Harris Methodist Southlake**, and

I understand that:

- (a) 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.
- (b) 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.

Signed: _____

Date: _____

Credentials Committee Recommendations: ____ **Recommend** ____ **Deny**

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Signed: _____

Date: _____

Recommended/Not recommended with the following modification(s) and reason(s):

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