

**LAKWOOD REGIONAL MEDICAL CENTER
DEPARTMENT OF SURGERY - Specialty of Neurosurgery**

APPLICANT NAME _____

**PLEASE
READ
BEFORE
COMPLETING**

Initial Applicants: **(1)** Physician shall have satisfied the criteria to be a candidate for the American Board of Neurosurgery or be Certified. **(2)** Completion of an approved residency in Neurosurgery.

Observations/Proctoring: 3 varied, major cases must be observed by an eligible observer. One of the 3 cases observed may be observed by the applicant's associate. Whenever possible, observers must be varied as well. This is a minimum requirement and based upon the review of the cases observed, additional observations may be required.

These requirements must be met in order to be eligible for the privileges being requested.

CORE PROCEDURES: Those considered to be intrinsic to the discipline and are routinely included in any hospital-based post graduate program. Core procedures may be granted in accordance with the above criteria.

Applicant is asked to line through any procedures he/she will not be performing

Core Procedures

Requested Granted Denied

| | |
|--|---|
| Admitting Attending Assisting Perform History and Physical Skull Shunts Trephines Craniotomy – Tumor; Hematoma; Exploration; Decompression & Trauma; Frontal sinus procedures Craniectomy Craniofacial procedures Hypophysectomy (transphenoidal) Lobectomy Stereotaxis Aneurysm Vascular malformation Repair lacerated arteries (intracranial) Intracranial bypass Pediatric cranial reconstruction Spine Spinal tap Discography Laminectomy – Cervical, Lumbar Fusion | Spine, cont. Cordotomy Rhizotomy Congenital anomalies Tumors Musculoskeletal biopsy Extracranial nerve surgery Fractures & Dislocations of spine – open reduction; open with use of metal screw, plate, nail, pin Peripheral Nerves Blocks Destruction by neurolytic agents Carpal tunnel syndrome Ulnar tunnel syndrome Ulnar nerve transposition Neurolysis Transposition Transection Tumors Neurorrhaphy Nerve grafts Microscope Phrenic nerve surgery Scalenotomy |
|--|---|

SPECIAL PROCEDURES: The following require documentation of additional training:

| | Requested | Granted | Denied |
|---|-----------|---------|--------|
| Use of Fluoroscopy (copy of current permit must be on file) | _____ | _____ | _____ |
| Laser Surgery – CO2 | _____ | _____ | _____ |

I have carefully reviewed this delineation sheet and declare myself competent in all the procedures requested above.

Signature of Applicant: _____ Date _____

APPROVALS

DEPARTMENT CHAIR _____ DATE _____

MEDICAL EXECUTIVE COMMITTEE _____ DATE _____

GOVERNING BOARD _____ DATE _____