

**THE NEW YORK EYE AND EAR INFIRMARY**

**DELINEATION OF PRIVILEGES**

**DEPARTMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY**

**AMBULATORY/IN-PATIENT**

**FELLOWSHIPS**

NAME:

( Print Name)

**Instruction:**

**Applicant: Please put a tick(✓) in the Privilege Requested Column**

**Chairman/Director: Please put a tick(✓) in the appropriate column.**

	<b><u>Director of Services</u></b>		
	Privilege Requested	Privilege Denied	Privilege Approved
<b>INPATIENT</b>			
<b>BREAST</b>			
Augmentation Mammoplasty		_____	_____
Excision of Lesion of Breast		_____	_____
Graft		_____	_____
Mastopexy		_____	_____
Mastotomy		_____	_____
Other Plastic Repair of Breast		_____	_____
Reconstruction of Breast		_____	_____
Reduction Mammoplasty		_____	_____
Removal of Breast Implants		_____	_____
Revision of Scar		_____	_____
Craniofacial Surgery		_____	_____
<b>ENDOSCOPY</b>		_____	_____
Facial, Forehead, Breast Procedure		_____	_____
<b><u>EAR</u></b>			
Plastic Operations on External Ear		_____	_____
<b><u>EYELIDS</u></b>			
Blepharoplasty		_____	_____
Periorbital and orbital lesion excision		_____	_____
Reconstruction of lids		_____	_____

	Privilege Requested	<u>Director of Services</u>	
		Privilege Denied	Privilege Approved
<b><u>INTEGUMENTARY SYSTEM</u></b>			
Candela Laser (proof of appropriate instruction course required)		_____	_____
Chin Implant		_____	_____
CO <sub>2</sub> Laser for Aesthetic Applications Skin Resurching (proof of appropriate instruction course required)		_____	_____
Dermabrasion		_____	_____
Electrolysis of Skin		_____	_____
Erbium Yag Laser (proof of appropriate instruction course required)		_____	_____
Evacuation of Hematoma		_____	_____
Excision of lesion of skin		_____	_____
Facial Plasty		_____	_____
Plastic Repair of Lip and Mouth		_____	_____
Revision of Scar Size Reduction		_____	_____
Skin Grafts, Flaps, except Lip or Mouth		_____	_____
<b><u>LIPOSUCTION</u></b>			
UltraSound Assisted Lipoplasty		_____	_____
<b><u>MICROSURGERY</u></b>			
<b><u>MUSCULOSKELETAL SYSTEM</u></b>			
Bone Graft		_____	_____
Mandibulectomy		_____	_____
Osteotomy		_____	_____
Removal of Bony Spurs		_____	_____
Repair of Diastis Recti		_____	_____
Maxillofacial Surgical Osteotomies		_____	_____
<b><u>NOSE</u></b>			
Nasal Reconstruction		_____	_____
Rhinoplasty		_____	_____
Submucous Resection		_____	_____
<b><u>NON-SURGICAL PROCEDURES</u></b>			
Removal of Sutures		_____	_____
<b><u>RADICAL ONCOLOGY</u></b>			
Procedures of Neck & Head, Trunk and Extremities		_____	_____
Surgery of Trama of face and Jaws		_____	_____

	Privilege Requested	<u>Director of Services</u>	
		Privilege Denied	Privilege Approved
<b>AMBULATORY</b>			
Amputation of finger, any joint of phalanx with or without skin graft		_____	_____
Argon laser for destruction of congenital hemangioma		_____	_____
Augmentation Mammoplasty		_____	_____
Biopsy of breast		_____	_____
Biopsy of lymphatic structure		_____	_____
Brow lift		_____	_____
Carpal tunnel release		_____	_____
Closed reduction of temporomandibular dislocation		_____	_____
Closed reduction of fracture with wiring of of maxillary teeth		_____	_____
CO <sub>2</sub> Laser for Aesthetic Applications /Skin Resurfacing ( <b>proof of appropriate instruction course required</b> )		_____	_____
Conjunctivoplasty OR free grafts to the to the conjunctiva		_____	_____
Dermabrasion (scars, tattoos, actinic changes)		_____	_____
Digital Osteotomy		_____	_____
Endoscopy: Facial, Forehead, Breast		_____	_____
Erbium Yag Laser ( <b>Proof of appropriate instruction course required</b> )		_____	_____
Excision of herniated fat pad		_____	_____
Excision of lesion of eyelid ( full thickness or part)		_____	_____
Excision of lesion of other soft tissue		_____	_____
Excision of lesion of tendon sheath of hand		_____	_____
Excision of lipoma		_____	_____
Excision of tendon sheath		_____	_____
Excision of xanthelasma		_____	_____
Facial Plasty (modified)		_____	_____
Facial plasty		_____	_____
Intermediate delay of any flap, primary delay, small flap or sectioning pedicel of direct flap.		_____	_____
Intranasal antrotomy		_____	_____
Liposuction		_____	_____
UltraSound Assisted Lipoplasty		_____	_____

**Director of Services**

Privilege Requested	Privilege Denied	Privilege Approved
Mastopexy not to exceed three hours	_____	_____
Mentoplasty, chin implants	_____	_____
Excision of minor tendons and phalanges	_____	_____
Split, or full thickness graft to cover ulcer, tip, or digit	_____	_____
Probing of nasolacrimal duct, with or without irrigation under general anesthesia	_____	_____
Removal of buried wire, pin, etc.	_____	_____
Removal of malignant lesion by any method	_____	_____
Removal of mammary implant material	_____	_____
Repair of ectropion or entropion	_____	_____
Resection of inferior turbinate (submucous)	_____	_____
Resection of lip for malignant lesion	_____	_____
Rhinoplasty	_____	_____
Scar revisions	_____	_____
Split skin graft, trunk, scalp, arms, legs, hands and feet up to 60 square inches	_____	_____
Suction lipectomy of three units only (e.g. thighs, abdomen, or buttock)	_____	_____
Surgical extraction of teeth	_____	_____
Suture of laceration of gum	_____	_____
Suture of laceration of mouth or palate	_____	_____
Tarsorrhaphy	_____	_____
Tenolysis of flexor tendons or fingers	_____	_____
Tenoplasty of hand	_____	_____
Tenosynovectomy of wrist, flexor or extensor tendon sheath	_____	_____

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

APPROVED: \_\_\_\_\_ DATE: \_\_\_\_\_

Donald Wood-Smith, M.D., Chairman  
Plastic and Reconstructive Surgery

Revised: 9.11.07