DELINEATION OF CLINICAL PRIVILEGES - PLASTIC SURGERY

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

GENERAL: The specialty of Plastic Surgery is not based upon an anatomical or organ system but special plastic surgical techniques. Adequate training in surgery and additional training to develop and learn to apply these special techniques prepare the plastic surgeon to operate on any area of the body. Primary concern is restoration of form and function to the integumentary and musculoskeletal systems. The following is a list of some deformities, defects, and abnormalities treated by the plastic surgeon. The list is neither inclusive or exclusive.

NOTE: This document is to be used in conjunction with DA Form 5440-13, Delineation of Clinical Privileges - General Surgery.

PROVIDER CODES	SUPERVISOR CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support/mission	5 - Not approved, insufficient facility support/mission

SECTION I - CLINICAL PRIVILEGES

Requested	Approved	
		a. Wounds and Wound Healing. Difficult wounds and wound healing problems, radiation injury, infection, cold and thermal injury
		b. Tissue Transplantation. Grafts of skin, fat, tissue, muscle, bone, cartilage, hair, and flaps
		c. Microvascular Surgery
		d. Head and Neck. Facial fractures and other trauma, scalp and bony craniofacial deformity reconstruction, cancer of the lip, anterior two-thirds of the tongue, salivary glands and skin, facial palsy, cleft lip and palate, congenital craniofacial and auricular abnormalities, orbital exenteration, and radical neck dissection
		e. Hand. Acute hand injuries, replantation, reconstruction, entrapment syndromes, tumors
		f. Extremities. Reconstruction, flap closure of defects, excision of tumors
		g. Trunk. Breast reconstruction, chest and abdominal wall reconstruction, pressure ulcer debridement and repair
		h. Genitourinary System. Hypospadias, reconstruction of the male and female genitalia
		i. Skin. Tumor excision, scar revision, tattoo removal, removal of keloid, hemangioma, lymphoma, nevi
		j. Aesthetic Surgery. Augmentation/reduction mammoplasty, dermabrasion, chemical peel, rhinoplasty, otoplasty, rhytidectomy, browlift, blepharoplasty, abdominoplasty, body contouring, implantation of alloplastic materials
		k. Suction assisted lipectomy. A technique of removal of fatty tissue in contour deformities using small incisions and cannulae attached to suction apparatus
		l. Oculoplastic procedures. Excision of eyelid tumors, reconstruction of eyelids, i.e., correction of acquired and congenital abnormalities of the eyelids, lacrimal system, and orbit
		m. Injections of steroids, botox, soft tissue fillers
		n. Administration of moderate sedation

LASER PRIVILEGES

Requests for laser privileges may require attendance at a formal laser training program(s), supporting documentation of training, experience, etc., acknowledgement of receipt of the MTF laser policy and procedural guidance, and review and approval by appropriate MTF personnel with oversight responsibility for laser therapy. The necessary documentation in support of this request is attached.

Requested					
Tuneable Dye	CO2	ARGON	ND:YAG		Approved
				a. Vaporization of tattoos	
				b. Excision of skin tumors	
				c. Reduction mammoplasty	

LASER PRIVILEGES *(Continued)*					
Requested					Approved
Tuneable Dye	CO2	ARGON	ND:YAG		
				d. Debridement & dissection of skin flaps	
				e. Skin resurfacing	
				f. Other *(Specify)*	

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*