

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS
Application for Privileges
N.J.A.C. 13:35-4A.12

GENERAL SURGERY

General Surgical Procedures:

PRIVILEGE CRITERIA

1. Attestation (Attachment 1 - in attestation format provided)

I am demonstrating clinical experience by attesting, in Attachment 1, to the number and type of procedures in general surgery which I performed in the last two years with acceptable results for patients of all age groups, except age groups specifically excluded from my practice, **plus** through additional material below.

2. Training (Attachments 2A and, depending upon privileges requested, Attachments 2B and 2C)

I am providing, as Attachment 2A, documentary evidence of **one** of the following:

(1) Current certification in surgery granted by the American Board of Surgery or the American Osteopathic Board of Surgery or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(2) Successful completion of an ACGME/AOA accredited residency training program in surgery, **OR**

(3) Supervised training in residency or fellowship or other equivalent experience in _____ (**another field**) **AND** active participation in examination process leading to certification in surgery.

Use of Laser (Attachment 2B):

In addition to documentation of general surgical training, for privileges for use of laser, I am providing, as **Attachment 2B**, documentary evidence of **one** of the following:

(1) Completion of a laser training program sponsored by an ACCME or AOA accredited provider of Category I CME documenting laser care, physics and clinical indications for utilization of the specific laser **and successful performance of laser procedures using the specific laser under direct clinical supervision**, or

(2) Documentation from the program director of an accredited residency training program attesting to the training in specific laser therapy during residency training.

Procedures Requiring Additional Training (Attachment 2C)

Licensee Name: _____ License Number: _____

I have attached, as Attachment(s) 2C, documentary evidence of the required additional training for each of the following procedures, if privileges are requested for these procedures:

Colonoscopy - Diagnostic - with or without polypectomy

Esophagogastroduodenoscopy

additional training:

- Documentation from the program director of an accredited residency training program attesting to the training during residency in the **requested** procedure

PLUS

- Documentation (**additional reference Attachment 3A**) from a privileged physician who has directly observed the applicant's successful performance or participation in the **requested** procedure.

3. Record Review/Clinical Observation (Attachment 3 and, depending upon privileges requested, Attachment 3A - in format provided):

References - Names, addresses and specialty, residency or observation only

I am providing, as Attachment 3, the names, addresses and specialty of three plenary licensed physicians who will directly submit references addressing my current competence based on their personal knowledge obtained either during a residency training completed during the two years preceding the date of this application or through personal observation during the two years preceding the date of this application.

A. Reference for Requested Procedure(s) requiring additional training

I am providing, as Attachment 3A, the name, address and specialty of a privileged physician who has directly observed my successful performance or participation in the **requested** procedure(s) **AND**

whom I have asked to directly submit a reference addressing my current competence based on their personal knowledge obtained through personal observation of my successful performance or participation in the requested procedure.

4. Log of procedures (Attachment 4A, for each privilege requested - in format provided)

I am providing, as Attachment 4A, a **separate log** listing all patients for whom, in an office setting or licensed ambulatory care facility setting during the two years preceding the date of the application, I performed each of the procedures for which I am requesting privileges. Each log includes a patient number, the type of anesthesia

Licensee Name: _____ License Number: _____

service provided, the surgery or special procedure performed and the date(s) of service. Patient names and other identifying data are redacted.

I am maintaining **in my office** a list or other means to identify the patient, based on the number included in the log.

Within each log, I have identified any patients contained in the log who have experienced complications relating to my performance of surgery or special procedures in an office setting or licensed ambulatory care facility setting and their resulting outcomes.

As part of the application for privileges process, from the logs I am providing, at least 5 cases, **with personal identifiers redacted**, that are representative of the type of procedures for which I requested privileges will be selected and I will be asked to provide patient records (or pertinent portions), along with a completed case summary form for each.

DELINEATION OF PRIVILEGES

I have checked the column on the left of those privileges listed below to indicate those procedures for which I do not hold hospital privileges and for which I am requesting alternative privileges to perform these procedure(s) in the office setting. I have attached additional materials, including documentation of successful completion of additional training, as was noted above as Attachments 2B, 2C, and 3A, if I am requesting privileges for the specific procedure which requires additional training, including use of laser.

Requested Privileges

ABDOMINAL SURGERY

_____ Laparoscopy - diagnostic
_____ Other *Please specify and provide supporting documentation on a separate page:*

ANORECTAL PROCEDURES

_____ Fulguration for neoplastic disease - see also laser
_____ External hemorrhoidectomy - see also laser
_____ Internal hemorrhoidectomy - see also laser
_____ Incision and drainage of perirectal abscess
_____ Surgical treatment of anorectal fistula
_____ Surgical treatment of anorectal fissure
_____ Colonoscopy - Diagnostic - with or without polypectomy **Requires additional training.**
_____ Esophagogastroduodenoscopy - **Requires additional training.**

Licensee Name: _____ License Number: _____

_____ Other - Please specify and provide supporting documentation on a separate page: _____

SKIN & APPENDAGES

_____ Management of burns with anesthesia services
_____ Excision of muscle foreign body with anesthesia services
_____ Other - Please specify and provide supporting documentation on a separate page: _____

VASCULAR

_____ Hemodialysis graft declot
_____ Other - Please specify and provide supporting documentation on a separate page: _____

OTHER

_____ Thyroid biopsy only
_____ Lymph node biopsy
_____ Placement of central venous catheter
_____ Lumbar puncture with anesthesia services
_____ Breast biopsy only

Use of Laser:

Each requires additional training in specific laser use.

_____ Fulguration for neoplastic disease: NdYAG, CO2
_____ External hemorrhoidectomy: NdYAG, CO2
_____ Internal hemorrhoidectomy: NdYAG, CO2

Please specify procedure(s) and laser (for each) and provide supporting documentation on a separate page: _____

I certify that my attestation of the number of procedures and any materials provided incident to this form (i.e. "supporting documentation") are true and accurate. I am aware that if any of the foregoing statements made by me or if the materials submitted by me are willfully false, I am subject to punishment.

Signature and printed name of Applicant

Date

Below this line for Administration Use Only

Application Tracking Record:

Licensee Name: _____ License Number: _____

Initial Receipt Date of Application _____
Transmittal Date to Outsourcing Entity _____
Supplemental Information Requested _____
Supplemental Information Received _____
Outsourcing Entity Recommendation _____
Outsourcing Entity Reviewer _____
Board Committee Review Date _____
Board Disposition Date _____

Licensee Name: _____ License Number: _____