

MEDSTAR UNION MEMORIAL HOSPITAL  
DELINEATION OF PRIVILEGES  
NEUROSURGERY

Name (print or type): \_\_\_\_\_  
Last
First
M.I.

CORE PRIVILEGES:	REQUESTED	RECOMMENDED	COMMENTS
Admitting/Consulting privileges for diagnoses generally regarded as part of the specialty of Neurosurgery			
Diagnostic Procedures: Myelography Arteriography Lumbar puncture			
Peripheral Nerves			
Spinal Procedures			
Cervical Procedures: Anterior approach Posterior approach Laminectomy Corpectomy Resection of extra/intradural mass, tumor, etc. Stabilization, reduction of fractures			
Thoracic Procedures: Cordotomy, cordectomy Resection of extra/intradural mass, etc.			
Lumbar Procedures: Discectomy, foraminotomy, laminectomy Intra/extradural exploration Lumbar peritoneal shunt			
Pain Procedures: Intracranial Spinal Percutaneous			
Intracranial Procedures: Supra/intra tentorial mass, tumor, etc. Transphenoidal hypophysectomy Trauma-debridement, removal of Intracranial hematoma(eg. Subdural, epidural, intracerebral)			
Aneurysm surgery Anterior circulation Posterior circulation			
AVM Shunting procedures			
<b>NON CORE PRIVILEGES:</b>			
Pediatric Surgery:			
Intracranial			
Spinal			
Trauma			
OTHER:			

**BOARD CERTIFICATION: All surgeons must be board certified and obtain within 5 years of graduating residency.**

(Electronic) By typing my name below, I certify the above statements to be true and correct to the best of my knowledge, and that this information can be used for the purpose of processing my MedStar Union Memorial Hospital Delineation of Privilege Form. (Non-Electronic) If filling out the delineation by hand, please provide your original signature and date.

\_\_\_\_\_  
 Applicant's Signature Date

---

Applicant Name

Reviewer's Comments:

I certify that I have reviewed the applicant's application for initial appointment or reappointment and request for delineation of privileges, and that I recommend the approval of the delineations of privileges as specified above.

---

Department Chief Signature

Date