Magna Health Systems, LLC
PRIVILEGE REQUEST FORM
GENERAL SURGERY

I am applying for the following privileges of which I am also credentialed at _____ an Illinois hospital.

Privileges requested for Magna Surgical Center

Requested	Granted	Procedure
_____	_____	Biopsies:
_____	_____	Axillary node
_____	_____	Breast
_____	_____	Cervical node
_____	_____	Muscle
_____	_____	Rectal
_____	_____	Testicular
_____	_____	Colonoscopy with biopsy
_____	_____	Colpotomy
_____	_____	Debridement of wound
_____	_____	Esophagoscopy
_____	_____	Excisions:
_____	_____	Calcium deposits
_____	_____	Cyst
_____	_____	Lesions- shoulder, skin
_____	_____	Lipoma
_____	_____	Masses, breast, other
_____	_____	Papilloma
_____	_____	Tumors
_____	_____	Fistulectomy
_____	_____	Foreign body removal
_____	_____	Frenulectomy – tongue
_____	_____	Hemorrhoidectomy
_____	_____	Herniorraphy – inguinal
_____	_____	Hernialrraphy – umbilical
_____	_____	Hydocelectomy
_____	_____	I & D Abscess
_____	_____	Lysis of adhesions
_____	_____	Pilonidal Cystectomy
_____	_____	Proctosigmoidoscopy
_____	_____	Rectal fissurectomy
_____	_____	Rectal polypectomy
_____	_____	Removal, breast implants
_____	_____	Repair, Costal defects
_____	_____	Repair, Torticollis

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Requested	Granted	Procedure
_____	_____	Sigmoidoscopy
_____	_____	Stitch granuloma
_____	_____	Suture, removal
_____	_____	Varicose vein ligation
_____	_____	Vermilionectomy
_____	_____	Laparoscopic Cholesystectomy
_____	_____	Laparoscopic Nissenfundoplication
		Laparoscopic Gastric Banding:
_____	_____	Laparoscopy surgical, gastric restrictive procedure; placement of adjustable gastric band (Gastric band and subcutaneous port components)
_____	_____	Revision of adjustable gastric band and/or Subcutaneous port
_____	_____	Removal of adjustable gastric band and/or Subcutaneous port
_____	_____	Replacement of adjustable gastric band and/or subcutaneous port
		Gastric Banding adjustments:
_____	_____	Fluroscopic guidance for needle placement
		Other (Please Specify)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____

Practitioner's Signature Print Name Date

_____

Medical Director Approval, Magna Surgical Center Date

_____

Governing Body Approval Date