DELINEATION OF CLINICAL PRIVILEGES - PODIATRY

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.

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

Category I.

Treat routine conditions of the foot and work under the supervision of a privileged podiatrist who assumes full responsibility of the provider's acts.

Requested	Approved	
		Category I clinical privileges

Category II. Includes Category I.

Examine, diagnose, and treat conditions of the feet requiring skills acquired during post-residency specialty training. Consultations should be used when there is doubt concerning the diagnosis or when there is evidence of systemic disease, as first manifested by pedal symptoms.

Requested	Approved	
		Category II clinical privileges

Category III. Includes Categories I and II.

Includes Categories I and II. Board certified or eligible. Prevention, diagnosis and treatment of complications involving the foot, arising from various systemic diseases, as well as the palliative and corrective treatment of local foot pathology.

Requested	Approved	
		Category III clinical privileges

AREAS OF FOOT PATHOLOGY

Requested	Approved		Requested	Approved	
		a. General Practice			d. Foot Orthopedics
		b. Foot Surgery			e. Podopediatrics
		(1) Common Podiatric Surgical Procedures *(Specify in list which follows)*			f. Podogeriatrics
					g. X-Ray Services (Interpretation)
		(2) Complex Reconstructive Surgery *(Specify in list which follows)*			
		c. Podiatric Dermatology			

COMMON PODIATRIC SURGICAL PROCEDURES

Requested	Approved	SKIN			NERVES
		a. Digital syndactylism			a. Decompression (posterior tibial nerve) tarsal tunnel
		b. Excision of cutaneous lesions, benign			b. Decompression sinus tarsi
		c. Excision of soft tissue lesions, cysts			c. Excision of neuroma
		d. Grafts (simple, rotational, pedicle flap)			
		e. Plastic revisions (forefoot)			**TENDONS**
		f. Removal of foreign body			a. Capsulotomy, midfoot with or without tendon lengthening
		g. Toenail procedures			
					b. Excision of cyst, (extra or intra-tendonous), foot
					c. Percutaneous Achilles lengthening

COMMON PODIATRIC SURGICAL PROCEDURES *(Continued)*

Requested	Approved	TENDONS *(Continued)*
		d. Plantar fascial release (Steindler, simple)(Endoscopic)
		e. Repair of ruptured tendon (forefoot)
		f. Tendon transfers (forefoot)
		g. Tendon lengthening (forefoot)
		h. Tenectomy or Capsulotomy
		OSSEOUS
		a. Arthrodesis I-P Joint, M-P Joint, 1st through 5th
		b. Arthrodesis T-M Joint
		c. Excision of accessory bone: including sesamoidectomy
		d. Excision of bone cyst, benign
		e. Hammer toe correction
		f. Akin type bunionectomy
		g. Keller type bunionectomy
		h. McBride type bunionectomy
		i. Ostectomy: any forefoot bone
		(1) Complete or partial excision of metatarsal head 1st through 5th
		(2) Bone graft harvest from foot
		j. Ostectomy: any midfoot or rearfoot bone, (partial, complete)
		(1) Complete or partial excision of metatarsal head 1st through 5th with implant
		(2) Excision of tarsal coalition
		(3) Heel spur with or without fascial releases

Requested	Approved	OSSEOUS *(Continued)*
		(4) Retrocalcaneal exostosis
		k. Correction of hallux valgus or bunion with proximal or distal osteotomy
		(1) Joint resection with implant
		(2) Arthrodesis (MTPJ, Lapidus)
		l. Ostectomy
		(1) Lesser tarsals
		(2) Metatarsals (distal, proximal)
		FRACTURES AND DISLOCATIONS
		a. Open reduction with or without fixation (digits, metatarsals)
		INFECTIONS
		a. Incision and drainage (deep, superficial)
		b. Debridement of osteomyelitic metatarsals and phalanges
		c. Partial digital amputation
		AMPUTATION
		a. Digital amputation
		b. Ray resection
		c. Metatarsal amputation
		d. Transmetatarsal amputation
		OTHER
		a. Ankle arthrotomy

COMPLEX RECONSTRUCTIVE SURGERY

Requested	Approved	TENDONS
		a. Tendon transfers (rearfoot)
		(1) Tendon suspensions (Young), (Hibbs), (Jones): tenodesis
		(2) Anterior/posterior tibial
		(3) Flexor transfer (rearfoot)
		(4) Peroneal transfer
		b. Tendon lengthening/repair: midfoot/ rearfoot
		OSSEOUS
		a. Arthroereisis
		b. Osteotomy with or without fixation
		(1) Calcaneus - talus
		c. Arthrodesis
		(1) Navicular-cuneiform
		(2) Midtarsal/subtalar
		(3) Triple arthrodesis

Requested	Approved	FRACTURES AND DISLOCATIONS
		a. Open reduction, with or without fixation
		(1) Calcaneus-talus
		(2) Lesser tarsals
		AMPUTATION
		a. Chopart amputation
		b. Symes amputation
		OTHER
		a. Ankle arthroscopy (diagnostic/surgical)
		b. Ankle arthroplasty (debridement, non-prosthetic)
		c. Ankle stabilization procedure: Tenoplastic/Ligamentoplastic
		d. Bone graft harvest from distal tibia/fibula
		e. Cavus foot reconstruction procedures
		f. Clubfoot release/reconstruction
		g. Endoscopic procedure
		h. Flatfoot reconstruction procedures
		i. Gastrocnemius recession

COMPLEX RECONSTRUCTIVE SURGERY *(Continued)*					
Requested	Approved	**OTHER** *(Continued)*	Requested	Approved	
		j. Microvascular procedure			n. Vertical talus release/reconstruction
		k. Repair of ruptured tendo-achilles			
		l. Suspected malignant neoplasms of the foot			
		m. Tendo-achilles, peroneus longus: Tendon lengthening			

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)*