(347) 599-2100
(347) 599-2633
313 43rd Street, Brooklyn, NY 11232

SCOB, LLC
Delineation of Privileges for Orthopedic Surgery Services

Applicant Name: ____________________

Category: ☐ Initial Appointment ☐ Reappointment ☐ Other: ____________________

Procedure Name	Requested	Approved	Denied
Knee Arthroscopy with :			
Menisectomy			
Synovectomy			
Chondroplasty			
Lateral Release			
ACL Reconstruction			
PCL Reconstruction			
Shoulder Arthroscopy with:			
Acromioplasty			
Synovectomy			
Manipulation			
Labral Repair			
Rotator Cuff Repair			
Capsular Repair			
Elbow Arthroscopy with:			
Synovectomy			
Excision Loose Body			
UCL Reconstruction			
Fractures: Minimal Soft Tissue Disruption			
Fractures: Marked Soft Tissue Disruption			
Closed Reduction Dislocation or Fracture Dislocation			
Minor Hand Surgery			
Skin Grafts			
Peripheral Nerve Repair			
Peripheral Nerve Transposition			
Bone Graft			
Primary/Secondary Tendon Repair			
Tenotomy			
Carpal Tunnel			
Bunionectomy			
Exostosis			
Excision Lesion (Bursa)			
Baker's Cyst Excision			
Arthrotomy			
Arthroplasty			
Arthrectomy-Menisectomy			

Procedure Name	Requested	Approved	Denied
Synovectomy			
Arthrodesis			
Manipulation of major and minor joints			
Laceration Repair			
Application of Cast			
Other:			

Provider Acknowledgement: I have requested privileges marked in the above list. I certify that I have training and experience in performing these procedures and have never been denied or have never relinquished (voluntary or involuntary) privileges to perform these procedures at other institutions. I attest that I do not have any health issues which could impact my ability to perform the privileges I requested.

Signature of Requesting Provider: ____ Date: ___________________

RECOMMENDATION: I have reviewed the applicant's request for Orthopedic Services and recommend that the requested privileges be approved and granted.

Medical Director Signature: ____ Date: ___________________

Board of Directors Confirmation by: ____ Date: ___________________