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

SCOB, LLC
Delineation of Privileges for Spine Services

Applicant Name: _____

Category: ☐ Initial Appointment ☐ Reappointment ☐ Other: _____

Procedure Name	Requested	Approved	Denied
Anterior Cervical Discectomy			
Application and Removal of Spinal Instrumentation			
Debridement			
Discectomy			
Discograms			
Epidural Injections			
Facet Joint Injections			
Fusion - Anterior/Posterior Cervical			
Laminectomy - Cervical			
Laminectomy - Lumbar			
Repair of Dura			
Open Treatment of Fractures			
Closed Treatment of Fractures			
Removal of Hardware			
Radiologic Interpretation			
C-Arm Fluoroscopy			
Topical Infiltration of Anesthesia			
Minor Nerve Blocks			
Local Infiltration of Anesthesia			
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 Spine Services and recommend that the requested privileges be approved and granted.

Medical Director Signature: _____ Date: _____

Board of Directors Confirmation by: _____ Date: _____