

MEDICAL PRIVILEGES REQUEST FORM

INTRODUCTION

This Medical Privileges request form must be accompanied or preceded by a completed application for medical staff appointment, including the necessary supporting documents. Many clinical privileges pertinent to the practice of medicine and surgery are listed below. This list contains both outpatient and inpatient items. The request for privileges must reflect both the applicant's and the facility's/staff's ability to carry out or support the various functions. This list is intended primarily for the generalist physician or physician extender performing these functions within the areas listed. Internists, pediatricians, and obstetricians may request additional appropriate privileges commensurate with their expertise within their specialty and the facility's ability to support the requested privileges. They should be presented in an attached list and referenced on this form under "other."

INSTRUCTIONS FOR COMPLETING THE FORM

Applicant: With a check mark in the appropriate location, indicate for each item your decision to request either *limited* or *full* privileges. *Limited* means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding *full* privileges. "Direct supervision" may be fulfilled via telephone consultation, if appropriate. *Full* means that the applicant is entitled to function independently, following standards consistent with the medical community at large. Be sure to sign the request as indicated on page 13.

Discipline-specific supervisor or consultant: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either *full*, *limited*, or *not recommended* (N.R.). Please explain any recommended limitations or denial of privileges on an attached sheet. Your recommendations are considered by the governing body when granting or not granting privileges.

I. OBSTETRICS (See Appendix C.2)

A. Minor

1. Normal prenatal/postpartum care
2. Normal spontaneous labor and vaginal delivery
3. Midline episiotomy and repair
4. Local and pudendal anesthesia
5. Repair of vaginal and cervical laceration
6. Management of mild preeclampsia
7. Amniotomy
8. Management of postpartum hemorrhage
9. Management of postpartum infection
10. Interpretation of external and internal fetal heart rate monitor tracings
11. Manual removal of placenta
12. Postpartum uterine exploration and/or curettage
13. Low forceps delivery
14. Curettage for incomplete abortion
15. Other (specify): _____

| | Applicant Requests | | Supervisor/ Consultant Recommends | | |
|--|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| | Ltd. | Full | N.R. | Ltd. | Full |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

B. Major

1. Multiple pregnancy

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

I. OBSTETRICS (See Appendix C.2)

2. Amniocentesis

| Applicant Requests | | Supervisor/ Consultant Recommends | | |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| Ltd. | Full | N.R. | Ltd. | Full |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I. OBSTETRICS (See Appendix C.2)

| | Applicant Requests | | Supervisor/ Consultant Recommends | | |
|---|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| | Ltd. | Full | N.R. | Ltd. | Full |
| 3. Breech delivery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Paracervical block | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Induction/stimulation of labor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Cesarean section | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Mid forceps delivery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Management of medical complications in pregnancy, i.e., diabetes, renal disease, severe preeclampsia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. OB ultrasound | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Other (specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Note: All clinicians granted minor or major obstetric privileges must also be qualified for and granted privileges in newborn resuscitation and stabilization.

II. GYNECOLOGY (See Appendix C.2)

A. Minor

| | Applicant Requests | | Supervisor/ Consultant Recommends | | |
|--|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| | Ltd. | Full | N.R. | Ltd. | Full |
| 1. I & D of vulvar or perineal abscess | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Biopsy of perineum, vulva, cervix, vagina | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Endometrial biopsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Insertion/removal of intrauterine device | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Dilatation and curettage | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Culdocentesis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Polypectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Vaginal or uterine packing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Other (specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

B. Major

| | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Pelvic exam under anesthesia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Tubal ligation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Marsupialization of Bartholin's cyst | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Abdominal hysterectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Incidental appendectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Vaginal hysterectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. A & P repair | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Peritoneoscopy (laparoscopy) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Salpingoophorectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Other (specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IV. MEDICINE

A. Hepatic and Gastrointestinal Disease

1. Cirrhosis

| Applicant Requests | | Supervisor/ Consultant Recommends | | |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| Ltd. | Full | N.R. | Ltd. | Full |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IV. MEDICINE

- 9. Cardiac arrhythmias
- 10. Cardioversion-medical
- 11. Cardioversion-electrical
- 12. Thrombophlebitis
- 13. Other (specify): _____

| Applicant Requests | | Supervisor/ Consultant Recommends | | |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| Ltd. | Full | N.R. | Ltd. | Full |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

E. Hypertension

- 1. Essential hypertension
- 2. Malignant hypertension
- 3. Other (specify): _____

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

F. Metabolic and Endocrine Disease

- 1. Diabetes mellitus
- 2. Diabetes mellitus, complicated by keto-acidosis or coma
- 3. Hypo/hyperthyroidism, uncomplicated
- 4. Hypo/hyperthyroidism, severe/complicated
- 5. Gout
- 6. Other (specify): _____

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

G. Collagen Disease

- 1. Lupus erythematosus
- 2. Scleroderma
- 3. Other (specify): _____

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

H. Arthritis

- 1. Rheumatoid arthritis
- 2. Osteoarthritis
- 3. Other (specify): _____

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I. Hematologic and Oncologic Diseases

- 1. Anemias
- 2. Thrombocytopenias
- 3. Cancer chemotherapeutic drug administration
- 4. Cancer patient management
- 5. Other (specify): _____

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

J. Neurological diseases

- 1. Cerebrovascular accident
- 2. Convulsive disorders
- 3. Parkinsonism
- 4. Degenerative neurological disorders
- 5. Meningitis

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IV. MEDICINE

6. Other (specify): _____

Applicant
Requests

Ltd.

Full

Supervisor/
Consultant
Recommends

N.R.

Ltd.

Full

V. SURGICAL OR PROCEDURAL (See Appendix C.3)

| Applicant Requests | | Supervisor/ Consultant Recommends | | |
|--------------------|------|-----------------------------------|------|------|
| Ltd. | Full | N.R. | Ltd. | Full |

D. Digestive System

1. I & D perirectal abscesses
2. Electrocautery/excision of anal condylomata
3. I & D oral abscesses
4. Biopsy mouth, tongue or lip lesions
5. Repair oral lacerations
6. Passage & use of Sengstaken-Blakemore tube
7. Gastric lavage
8. Liver biopsy, closed
9. Proctosigmoidoscopy, anoscopy
10. Proctosigmoidoscopy, anoscopy, w/ biopsy
11. Diagnostic paracentesis
12. Therapeutic or decompressive paracentesis
13. Closed reduction of hernias
14. Gastroscopy
15. Other (specify): _____

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

E. Orthopedic

1. Muscle biopsy
2. Injection of tendon sheath, ligament trigger points, or bursae
3. Arthrocentesis
4. Bone marrow aspiration
5. Bone marrow biopsy
6. Closed reduction of simple fractures of phalanges, clavicles, ribs, toes
7. Closed reduction of simple fractures of radii, ulnae, humeri, tibiae, fibulae
8. Reduction of dislocations of hip, elbows, shoulders, fingers
9. Application of casts and splint
10. Non-surgical & non-neurological traction
11. Other (specify): _____

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

F. Thoracic

1. Thoracentesis
2. Tube thoracostomy
3. Pleural biopsy
4. Bronchoscopy

| | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

