



# ORTHOPEDIC SURGERY

## RESIDENCY LOGBOOK

### Orthopedic Surgery Residency Program Surgical Logbook Verification Form

Academic Year: ☐ June 2026 ☐ December 2026

Hospital Name:

### Resident Details

Resident Name:

Residency Level:

☐ Y2 ☐ Y3 ☐ Y4 ☐ Y5



## Orthopedic Surgery Residency Program – Surgical Logbook

### ***Specialist Supervisor (Same Hospital)***

Name:

Signature:

### ***Head of Orthopedic Department (Hospital)***

Name:

Signature & Stamp:

Date:

### ***Senior Resident Reviewer (Same Y5)***

Logbook Review by Senior Resident (From Other Hospital)

*(After Department Attestation)*

Name:

Date:

Signature:

*Completing this Surgical Logbook is mandatory to enter exams.*

## Orthopedic Department

### Orthopedic Surgery Residency Program

#### *Residency Year 2 – Minimum Required Procedures*

Procedure	Required Number
Closed reduction and casting	15
Wound care & debridement	15
Nerve decompression	10
Tendon repair	5
External fixator application	5
Supracondylar humerus fracture fixation	5
K-wire fixation	8
DHS / PFN / Hemiarthroplasty	10

## Orthopedic Surgery Residency Program – Year 2

### Procedure Group: Closed reduction and casting (Required cases: 15)

No.	Procedure Name	Patient Name	Patient ID	Specialist Name	Date
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

**Procedure Group: Wound care & debridement (Required cases: 15)**

No.	Procedure Name	Patient Name	Patient ID	Specialist Name	Date
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

**Procedure Group: Nerve decompression (Required cases: 10)**

No.	Procedure Name	Patient Name	Patient ID	Specialist Name	Date
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

**Procedure Group: Tendon repair (Required cases: 5)**

No.	Procedure Name	Patient Name	Patient ID	Specialist Name	Date
1					
2					
3					
4					
5					

**Procedure Group: External fixator application (Required cases: 5)**

No.	Procedure Name	Patient Name	Patient ID	Specialist Name	Date
1					
2					
3					
4					
5					



**Procedure Group: Supracondylar humerus fracture fixation (Required cases: 5)**

No.	Procedure Name	Patient Name	Patient ID	Specialist Name	Date
1					
2					
3					
4					
5					

**Procedure Group: K-wire fixation (Required cases: 8)**

No.	Procedure Name	Patient Name	Patient ID	Specialist Name	Date
1					
2					
3					
4					
5					
6					
7					
8					

**Procedure Group: DHS / PFN / Hemiarthroplasty (Required cases: 10)**

No.	Procedure Name	Patient Name	Patient ID	Specialist Name	Date
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					