Applicant's Name

_____

OB/GYN SURGERY PRIVILEGES

I hereby request surgical privileges in the specialty of General Surgery as shown in this form. I understand that privileges granted are subject to a bi-annual review coinciding with reapplication for medical staff membership. I also understand that application for additional or new procedures can be made at any time with proper documentation.

Please indicate with an "X" in the appropriate box and by signature at the end of this document the procedures you are requesting privileges for.

Applied for	**Approved**	
❑ Evaluation and diagnosis of medical conditions to determine need for surgical intervention with regard to appropriate consultation when prudence and good medical care require so.	❑ YES	❑ NO
❑ ** Hysteroscopy	❑ YES	❑ NO
❑ **Endometrial ablation- electrosurgical	❑ YES	❑ NO
❑ **GIFT	❑ YES	❑ NO
❑ **Laser-intra-abdominal	❑ YES	❑ NO
❑ **Laser-laparoscopy	❑ YES	❑ NO
❑ **Laser-lower genital	❑ YES	❑ NO
❑ **Removal of condyloma (laser)	❑ YES	❑ NO
❑ Anterior colporrhaphy ❑ Posterior colporrhaphy	❑ YES ❑ YES	❑ NO ❑ NO
❑ Bartholin gland, excision or maruspialization	❑ YES	❑ NO
❑ Biopsy: vulva, cervix, vagina	❑ YES	❑ NO
❑ Cautherization vaginal cyst	❑ YES	❑ NO
❑ Cervical conization	❑ YES	❑ NO
❑ D&C-diagnostic	❑ YES	❑ NO
❑ D&C-therapeutic	❑ YES	❑ NO
❑ Exam under anesthesia	❑ YES	❑ NO
❑ Foreign body removal from vagina	❑ YES	❑ NO
❑ Hymeotomy	❑ YES	❑ NO
❑ IUD removal	❑ YES	❑ NO
❑ IVF	❑ YES	❑ NO
❑ Laparoscopy-pelviscopy	❑ YES	❑ NO
❑ Laparoscopy-tubal ligation	❑ YES	❑ NO
❑ Laparotomy-limited/mini	❑ YES	❑ NO

❑ Lysis of adhesions of the clitoris	❑ YES	❑ NO
❑ Myomectomy (intrauterine)	❑ YES	❑ NO
❑ Perineoplasty-simple	❑ YES	❑ NO
❑ Perineorrhaphy	❑ YES	❑ NO
❑ Polypectomy-cervical or uterine	❑ YES	❑ NO
❑ Removal of adnexal-partial/complete	❑ YES	❑ NO
❑ Removal of condyloma (surgical)	❑ YES	❑ NO
❑ Repair surgical rent-bladder,bowel	❑ YES	❑ NO
❑ Simple excision of skin lesion	❑ Yes	❑ NO
❑ Vaginal stenosis release	❑	❑
❑ Vulvar or labial biopsy	❑ YES	❑ NO
❑ ** Xray interpratation	❑ YES	❑ NO
❑ **LASERS *Nd:YAG laser, CO2 laser	❑ YES	❑ NO
❑ Radiography Use of Modality & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Ultrasound Use of Modality & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Fluoroscopy Use of Modality with State License & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Local anesthesia	❑ YES	❑ NO
❑ Conscious Sedation	❑ YES	❑ NO
❑ Supervision of Conscious Sedation Trained Registered Nurse	❑ YES	❑ NO
❑ OTHERS NOT LISTED	❑	❑
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

*** DOCUMENTATION OF TRAINING AND EXPERIENCE IS REQUIRED FOR THOSE PROCEDURES*

Signature of Applicant	Date
Signature of QI committee chairperson	Date recommended
Signature of Governing Body chairperson	Date recommended