Hospital Logo

Hospital Name

Hospital Address

**Application for Clinical Privileges – Gastroenterology**

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| Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff Category: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Effective from \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Request all privileges desired by checking the applicable requested box.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Request | Not Requested |  | Granted | Not Granted |
|  |  | Evaluate, diagnose, treat, medically manage and provide consultation to patients of all ages with diseases, injuries and disorders of the digestive organs, including the stomach, bowels, liver, gallbladder and related structures such as the esophagus and pancreas, including the use of diagnostic and therapeutic procures using endoscopes to visualize internal organs. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills. |  |  |
|  |  | Admit patients to the appropriate level of care. |  |  |
|  |  | **Procedures: Remove those procedures not within capabilities and capacities of Hospital** |  |  |
|  |  | Proctoscopy and/or flexible sigmoidoscopy |  |  |
|  |  | Colonoscopy with and without biopsy or polypectomy including colonic dilation |  |  |
|  |  | Upper gastrointestinal endoscopy with or without biopsy including hemostasis (injection, electrosurgical or ligation) and sclerotherapy or banding of esophageal varices and dilation of the esophagus or pylorus |  |  |
|  |  | Use of energy sources (excluding lasers) during an endoscopic procedure |  |  |
|  |  | Percutaneous endoscopic gastrostomy (PEG) |  |  |
|  |  | Percutaneous liver biopsy |  |  |
|  |  | Breath test performance and interpretation |  |  |
|  |  | Enteral and parenteral alimentation |  |  |
|  |  | Gastrointestinal motility studies and 24-hour pH monitoring |  |  |
|  |  | Interpretation of gastric, pancreatic and biliary secretory tests |  |  |
|  |  | Nonvariceal hemostasis (upper and lower) |  |  |
|  |  | Variceal hemostasis (upper and lower) |  |  |
|  |  | Ultrasound including endoscopic ultrasound and fine-needle aspiration |  |  |
|  |  |  |  |  |
|  |  | **Moderate Sedation:** **Remove this privilege not within capabilities and capacities of Hospital** |  |  |
|  |  | Moderate/Conscious Sedation |  |  |
|  |  | Other Privileges Desired (Not Listed Above) |  |  |
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**Signature of Applicant:**

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I am entitled to perform and that I wish to exercise at (Insert Name of Hospital).

I also understand that by making this request I am bound by the applicable Medical Staff Bylaws and/or policies of (Insert Name of Hospital). I also attest that my professional liability insurance covers the privileges I have requested.

I understand that it is my responsibility to provide (Insert Name of Hospital) with documentation of my education, training, current experience and information regarding the number of services and procedures I have performed in order to assist the Medical Staff in the determination of competency or continued competency.

I affirm that I will obtain a consultation with a qualified medical staff member when it is in the best interest of the patient and/or when my expertise does not meet the clinical needs of the patient.

Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws and related documents.

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**Signature of Applicant Date**

**Medical Staff/Credentials Committee Recommendations – Privileges**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s): Please check the applicable box(es)

|  |  |
| --- | --- |
|  | Recommend all requested privileges |
|  | Do not recommend any of the requested privileges |
|  | Recommend privileges with the following conditions/modifications/deletions (listed below) |

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| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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**Medical Staff/Credentials Committee Date**

**Signature of Applicant:**

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I am entitled to perform and that I wish to exercise at (Insert Name of Hospital).

I also understand that by making this request I am bound by the applicable Medical Staff Bylaws and/or policies of (Insert Name of Hospital). I also attest that my professional liability insurance covers the privileges I have requested.

I understand that it is my responsibility to provide (Insert Name of Hospital) with documentation of my education, training, current experience and information regarding the number of services and procedures I have performed in order to assist the Medical Staff in the determination of competency or continued competency.

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**Signature of Applicant Date**

**Medical Staff/Credentials Committee Recommendations – Privileges**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s): Please check the applicable box(es)

|  |  |
| --- | --- |
|  | Recommend all requested privileges |
|  | Do not recommend any of the requested privileges |
|  | Recommend privileges with the following conditions/modifications/deletions (listed below) |

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| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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**Medical Staff/Credentials Committee Date**

**Board of Directors Determination**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following determination(s): Please check the applicable box(es).

|  |  |
| --- | --- |
|  | Approve all requested privileges |
|  | Approve none of the requested privileges |
|  | Approve the following privileges with the following conditions/modifications/deletions (listed below) |

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| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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Board of Directors Date

Hospital Name

**Board of Directors Determination**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following determination(s): Please check the applicable box(es).

|  |  |
| --- | --- |
|  | Approve all requested privileges |
|  | Approve none of the requested privileges |
|  | Approve the following privileges with the following conditions/modifications/deletions (listed below) |

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| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
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Board of Directors Date

Hospital Name

Form Approved By:

Medical Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Board of Directors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date