Hospital Logo

Hospital Name

Hospital Address

**Application for Clinical Privileges – Obstetrics and Gynecology**

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

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

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| --- | --- | --- | --- | --- |
| Request | Not Requested |  | Granted | Not Granted |
|  |  | Obstetrics: Admit, evaluate, diagnose, treat, and provide consultation to patients of adolescent and adult female patients and/or provide medical and surgical care of the female reproductive system and associated disorders, including major medical diseases that are complicating pregnancy. 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.  Gynecology: Admit, evaluate, diagnose, treat, and provide consultation and the pre-, intra- and postoperative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system and nonsurgical treat disorders and injuries of the mammary glands. 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. |  |  |
|  |  | **Obstetric Procedures: Remove those procedures not within capabilities and capacities of Hospital** |  |  |
|  |  | Third trimester amniocentesis |  |  |
|  |  | OB Ultrasound |  |  |
|  |  | Normal labor and delivery with or without episiotomy |  |  |
|  |  | Local anesthesia, pudendal and paracervical blocks |  |  |
|  |  | Augmentation of labor |  |  |
|  |  | Operative delivery including the use of forceps and vacuum |  |  |
|  |  | Version and extraction |  |  |
|  |  | Repair of vaginal, cervical or perineal lacerations |  |  |
|  |  | Cesarean section including hysterectomy |  |  |
|  |  | Cervical cerclage |  |  |
|  |  | Management and delivery of multiple pregnancy |  |  |
|  |  | Circumcision (newborn) |  |  |
|  |  | Placement of arterial and central venous catheters for hemodynamic monitoring |  |  |
|  |  | Delivery of fetal demise |  |  |
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|  |  | Other Privileges Desired (Not Listed Above) |  |  |
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|  |  | **Gynecology Procedures: Remove those procedures not within capabilities and capacities of Hospital** |  |  |
|  |  | Paracervical or pudendal block |  |  |
|  |  | Marsupialization or excision of Bartholin cyst or abscess |  |  |
|  |  | Soft tissue biopsy of the genital-urinary tract or incidental biopsy of other lesions encountered in the course of a gynecologic procedures |  |  |
|  |  | Simple vulvectomy |  |  |
|  |  | Hymenotomy |  |  |
|  |  | Dilation and curettage |  |  |
|  |  | Colpotomy, Culdocentesis |  |  |
|  |  | Colpocleisis |  |  |
|  |  | Colposcopy |  |  |
|  |  | Colpectomy, partial or complete |  |  |
|  |  | Hysterectomy, abdominal, total or subtotal with or without BSO |  |  |
|  |  | Myomectomy via laparotomy |  |  |
|  |  | Salpingectomy, sapling-oophorectomy, salpingectomy, oophorectomy and/or resection of ovarian cyst |  |  |
|  |  | Cold-knife conization of the cervix |  |  |
|  |  | Colphorrhaphy for urethrocele, cyctocele or rectocele |  |  |
|  |  | Fistula repair: recto- and vesico-vaginal |  |  |
|  |  | Repair of enterocele |  |  |
|  |  | Suprapubic catheter placement |  |  |
|  |  | Abdominal retropubic urethropexy (Burch; Marshall-Marchetti-Krantz, etc.) |  |  |
|  |  | Cystoscopy as part of a gynecologic procedure |  |  |
|  |  | Laparoscopy (diagnostic) |  |  |
|  |  | Basic operative Laparoscopy including treatment of endometriosis; assisted vaginal hysterectomy or uteri anticipated to be less than 12 weeks gestation size; salpingectomy; salpingostomy; salpingo-oopherectomy; lysis of adhesions; myomectomy (pedunculated myoma); and ovarian cystectomy |  |  |
|  |  | Incidental appendectomy |  |  |
|  |  | Incidental bladder repair |  |  |
|  |  | Incidental hernia repair (umbilical, incision, ventral) |  |  |
|  |  | Abdominal paracentesis |  |  |
|  |  | Tubal Ligation |  |  |
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|  |  | 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**

**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