


**AMBULATORY SURGERY DIVISION
REQUEST FOR PRIVILEGES
GYNECOLOGY**


Name: _____

Date: _____

The minimum education, training and experience qualifications for Medical Staff membership are delineated in the Medical Staff Bylaws, Rules and Regulations and/or Policies and Procedures of each facility. Please consult these documents prior to requesting privileges.

 Indicates privilege that is **not** available in this specialty at this facility.

To request privileges, please place an "X" in the appropriate facility column.

| Bailey Square Surgery Center | Oakwood Surgery Center | Surgicare of South Austin | North Austin Surgery Center | Description of procedures for which privileges are requested: | Approved | Denied |
|------------------------------|------------------------|---|-----------------------------|--|----------|--------|
| | | | | Abdominal Hysterectomy, if necessitated by findings during planned procedure | | |
| | | | | Anterior Repair | | |
| | | | | Bartholin Duct Cystectomy | | |
| | | | | Biopsy of the Cervix | | |
| | | | | Biopsy of Vagina | | |
| | | | | Biopsy of Vulva | | |
| | | | | Bladder Suspension | | |
| | | | | Bladder Neck Suspension | | |
| | |  | | Burch Procedure, Open | | |
| | | | | Burch Procedure, Laparoscopic | | |
| | | | | Cervical Cerclage Placement | | |
| | | | | Cervical Polypectomy | | |
| | | | | Colposcopy | | |
| | | | | Conization of Cervix | | |
| | | | | Culdocentesis | | |
| | | | | Cystoscopy | | |
| | | | | D & C - Diagnostic | | |
| | | | | D & C - Incomplete Abortion | | |
| | | | | D & C - Missed Abortion with Suction up to 12 completed weeks gestation | | |
| | | | | Diagnostic Laparoscopy | | |
| | | | | Diagnostic Laparoscopy - CO2 Lasering Endometriosis | | |
| | | | | Diagnostic Laparoscopy with Removal Tubal Pregnancy | | |
| | | | | Endometrial Ablation, (Documentation of training/experience required) | | |
| | | | | Exam Under Anesthesia | | |
| | | | | Excision of Bartholin Duct Cyst | | |
| | | | | Excision of Skene's Duct Cyst | | |
| | | | | Excision of Urethral Caruncle | | |
| | | | | Exploration of Surgical Wound | | |
| | | | | Hymenectomy | | |
| | | | | Hymenotomy | | |
| | | | | Hydatid Mole Evacuation | | |
| | | | | Hysteroscopy, Diagnostic and Therapeutic | | |
| | | | | Incisional Hernia Repair | | |
| | | | | I & D Bartholin Duct Cyst | | |

| Bailey Square Surgery Center | Oakwood Surgery Center | Surgicare of South Austin | North Austin Surgery Center | Description of procedures for which privileges are requested: | Approved | Denied |
|------------------------------|------------------------|---------------------------|-----------------------------|--|----------|--------|
| | | | | IV Conscious Sedation | | |
| | | | | Laparoscopic Removal of Hydrosalpinx | | |
| | | | | Laparoscopic Pelviscopy | | |
| | | | | Laparoscopic Assisted Vaginal Hysterectomy | | |
| | | | | Laparoscopic Assisted Supracervical Hysterectomy | | |
| | | | | Laparoscopic Procedures Using CO2 Laser, (Documentation required) | | |
| | | | | Laparoscopic Salpingo-oophorectomy | | |
| | | | | Lapartomy if necessitated by findings during planned procedure | | |
| | | | | Laser Vaporization of Cervix, (Documentation required) | | |
| | | | | Laser Vaporization of Condyloma, (Documentation required) | | |
| | | | | Lesions, Excision | | |
| | | | | LLETZ, Procedure | | |
| | | | | Loop Electrosurgical Excision Procedure of Cervix | | |
| | | | | Microwave Endometrial Ablation | | |
| | | | | Novasure Ablation | | |
| | | | | Perineoplasty | | |
| | | | | Posterior Repair | | |
| | | | | Removal IUD | | |
| | | | | Removal of Norplant | | |
| | | | | Repair of Vaginal Laceration | | |
| | | | | Semm Hysterectomy | | |
| | | | | Suprapubic Cystotomy | | |
| | | | | Thermachoice Ablation | | |
| | | | | Tubal Laparoscopy Falope Rings Application | | |
| | | | | Tubal Laparoscopy Fulguration | | |
| | | | | Tubal Laparoscopy Hulka Clips Application | | |
| | | | | Tubal Ligation (Mini Laparotomy) | | |
| | | | | Tubal Reanastomosis | | |
| | | | | TVT- Tension-free Vaginal Taping | | |
| | | | | Ultrasound, Limited | | |
| | | | | Urethral Caruncle Fulguration | | |
| | | | | Vaginal Hysterectomy | | |
| | | | | Vessica Bladder Neck Suspension | | |
| | | | | Extended Recovery, not to exceed 23 hours | | |
| | | | | Documentation of Training and/or Experience Required for the following: | | |
| | | | | Operative Hysteroscopy | | |
| | | | | Ablation | | |
| | | | | Resection of Myoma | | |
| | | | | Resection of Uterine | | |
| | | | | Polypectomy | | |
| | | | | Essure Tubal Ligation | | |
| | | | | Operative Laparoscope | | |
| | | | | Adnexal Removal | | |
| | | | | LAVH (Laparoscopic Assisted Vaginal Hysterectomy) | | |
| | | | | Myomectomy | | |
| | | | | Burch | | |
| | | | | Tension-free Vaginal Tape | | |

____ Laser privileges requested (**documentation of training and/or experience required, see attached form**)

____ Reads own xray/xray images (**must make note of findings in op report**)

If the privilege/condition you are requesting is not included on this form, please provide a separate written request and appropriate documentation of training and/or experience.

Based upon my training and experience, I hereby request privileges in the specialty of Gynecology, as shown on this form. I understand that privileges granted to me may differ from those requested. I further understand that the completion of this form does not preclude me from requesting additional privileges in the future.

In exercising the privileges granted to me, I agree to strictly abide by the facility's Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures. I acknowledge that any restrictions on the clinical privileges granted to me are waived in an emergency/disaster situation, and in such a situation, my clinical privileges will be governed by the facility's Medical Staff Bylaws and Rules and Regulations.

Applicant's Signature & Date

DEPARTMENT RECOMMENDATION

I have reviewed the applicant's credentials and request for the above privileges. The following recommendations are made:

___APPROVED ___DENIED ___DEFERRED ___OTHER:_____

Department Chairperson's Signature & Date

GOVERNING BOARD APPROVAL

Approval Date per Minutes: ____/____/____
(Privileges expire two years from Approval Date.)