

CRITERIA FOR GRANTING OB/GYN AND GYN ONCOLOGY PRIVILEGES

Please review these categories carefully to determine those privileges for which you are qualified. Indicate your request below by checking the appropriate category. If you feel that special training or experience qualifies you for advanced privileges, please contact the OB/GYN department chair.

CLASS 1

CRITERIA FOR GRANTING – Physicians must have completed a residency in a specific area relating to the privilege they are requesting and at least 100 vaginal and/or abdominal deliveries. Physicians must be board certified or eligible in Obstetrics/Gynecology.

CLASS 2

CRITERIA FOR GRANTING: Physicians must be board certified in OB/GYN and have specialty training and have completed a gynecologic/oncology fellowship.

PROCTORING REQUIREMENTS: In accordance with the Medical Staff Bylaws and the requirements of the Joint Commission on Accreditation of Healthcare Organizations, each new applicant and reappointee (asking for new privileges) to the medical staff of Foothill Presbyterian Hospital must have a minimum of six cases proctored. Three must be proctored by an Active or Courtesy staff member of the OB/GYN department and an additional three may be accepted from another facility, if proctored by a member of the FPH medical staff.

We will appreciate your assistance and cooperation in ensuring that this is accomplished. To assist us, we are requesting that for your first six cases or until otherwise notified, you obtain a proctor for your surgical cases. Your proctor is named in your “Welcome to the Staff” letter. A list of other available proctors is attached for your convenience. You should have no more than one-third of your proctored cases proctored by an associate in your office.

The proctored cases should be representative of the privileges you are requesting in your specialty. If you are unable to obtain a proctor, please call the Medical Staff Office and they will be happy to assist you. In the case of an emergency operative procedure, you may proceed without a proctor, only with the approval of the chief of your department or his or her designee.

Please be aware that proctors may intervene regarding proposed treatment during a procedure if they deem in their judgment that it is absolutely necessary. On completion of the required number of proctored cases, the surgery department will review and evaluate these reports. You will be advised of the decision regarding your satisfactory completion of proctoring or if there will need to be additional proctoring requirements. We are sure you understand the need to require your cooperation in these efforts. These are not only mandated requirements, but they are essential to the maintenance of the quality of care established by the medical staff at Foothill Presbyterian Hospital. Again, we appreciate your assistance in this matter.

If you have any questions regarding these proctoring requirements, please do not hesitate to contact the Medical Staff office at (626) 857-3241.

We welcome you.

Name: _____

Appointment/Reappointment: A minimum of three (3) cases of any of the following elective procedures **MUST** be proctored by a member of the Active Staff who has been granted the privilege.

Reappointment: A minimum of three (3) cases of any of the following elective procedures **MUST** be performed within the past two years. If this is not met, the request will be evaluated and monitoring may be re-assigned.

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	CORE OB/GYN PRIVILEGES	APPROVED	DENIED
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<input type="checkbox"/>	<hr/>	These procedural privileges are customarily performed by board certified, board eligible or fully trained general surgeons;	<input type="checkbox"/>	<input type="checkbox"/>
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Documentation of specific training and current competence in core procedural privileges may be required;

Core Procedural Privileges have no asterisk.

REQUESTED	# PERFORMED IN LAST 2 YEARS	CLASS 1 OB/GYN	APPROVED	DENIED
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<input type="checkbox"/>	<hr/>	D & C (Obstetrical)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	D & C (Non Obstetrical)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	I&D Abscess-(Gyn oriented)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Bartholin Cystectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Biopsy Vulva	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Biopsy Cervix	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Perineotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Perineorrhaphy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Rectocele/Cystocele Repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Enterocoele Repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Cysto-urethrocele Repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Exc. Skenes Duct Cyst	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Exc. Urethral Caruncle	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Vulvectomy-simple	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Hysterectomy - Vaginal	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Hysterectomy-Abdominal	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Uterine Suspension	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Retropubic Urethropexy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Salpingectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Oophorectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Hymenotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Incompetent OS Surgery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Incisional Herniorrhaphy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Fundectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Salpingostomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Tubal Ligation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Laparoscopic Tubal Ligation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Urethral Caruncle Fulguration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<hr/>	Umbilical Herniorrhaphy	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	CLASS 1 OB/GYN Cont.	APPROVED	DENIED
<input type="checkbox"/>	_____	La Forte Vaginal Repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Repair Recto-Vaginal Fistula	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Hystero-Salpingogram	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Meckel's Diverticulum	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Wedge Resection of Ovaries	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Hydatid Mole Evacuation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Salpingoplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Tubal Implantation into Uterus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Evisceration Repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Colpectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Colpotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Trachelectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Removal Foreign Body (GYN oriented)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Cesarean Section	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Bilateral Tubal Ligation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Appendectomy-Incidental	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Repair Surgical Rectal-Bladder, Bowel	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Ureteral Repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Exc. Skin Lesions	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Breast Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Cesarean Section-Classical	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Low Cervical	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Delivery-uncomplicated	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Breech Extraction	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Cystoscopy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Version and Extraction	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Diagnostic Hysteroscopy/ Endometrial Ablasion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Mid-Forceps	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Operative Laparoscopic Assisted Vaginal Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Repair Skin Lacerations	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Skin & Subcutaneous Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Incision & Drainage Superficial Abscess	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Circumcision	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Laser Privileges	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Laparoscopic Supracervical Hysterectomy (Accompanied With Certificate)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	TVT (Accompanied With Certificate)	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	CLASS II GYN ONCOLOGY	APPROVED	DENIED
<input type="checkbox"/>	_____	Passage of Ureteral Stents	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Proctoscopy/Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Treatment of Invasive Cancer Of the Cervix by Radical Hysterectomy with or without Lymph Node Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Splenectomy/Diaphragm (Partial Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Vulvectomy-Radical/Node Dis.	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Treatment of Invasive Cancer Of the Vulva by Radical Vulvectomy with or without Lymph Node Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Skin Grafting/Flaps	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Node Dissection includes Groin, Pelvic,Aortic, Peri-anal And Scalene	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Liver Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Gynecological Reconstruction By Split Thickness Graft	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Gynecological Reconstruction By Bulbocavernosus Gracilis Or Rectus Abdominus Myocutaneous Grafts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Total Parenteral Nutrition	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Cancer Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	EGD	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Thoracentesis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Paracentesis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Colostomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Exentration: Anterior	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Exentration: Posterior	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Exentration: Total	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Ileal Conduit	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Indiana Pouch	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Intersitital Implant	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Ureteral Reanastomosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Ureteral Reimplantation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Urethral Diverticulum Excision & Marsupialization	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Vaginal Reconstruction (Absent Vagina)	<input type="checkbox"/>	<input type="checkbox"/>

I certify that I have had the necessary training and experience to perform the procedures that I have requested. All privileges delineated have been individually considered and have been recommended based upon practitioner's specialty, licensure, specific training, experience, health status, current competency and peer recommendations.

SIGNATURE OF APPLICANT

DATE

CHAIR, OB/GYN DEPARTMENT

DATE