



UROLOGY PRIVILEGES REQUEST FORM

Please review these privileges carefully to determine those privileges for which you are qualified, either by proof of training or experience. Physicians requesting privileges should have completed an approved residency and be board certified or eligible in urology, or have training in a qualified program.

Privileges: Admit, treat and consult without limitation.

<u>PRIVILEGES REQUESTED</u>	<u>APPROX. # PERFORMED LAST 2 YEARS</u>	<u>APPROVED AND/OR COMMENTS</u>
_____ CIRCUMCISION	_____	_____
_____ MEATOTOMY	_____	_____
_____ CYSTOSCOPY	_____	_____
_____ RETROGRADE KIDNEY STUDIES	_____	_____
_____ CYSTO W/ TRIAL EXTRACTION STONE	_____	_____
_____ CYSTO W/ FULGURATION BLEEDING	_____	_____
_____ CYSTO W/ BLADDER BIOPSY	_____	_____
_____ INGUINAL HERNIORRHAPHY	_____	_____
_____ HYDROCELE, SPERMATOCELE, VARISCO	_____	_____
_____ VASECTOMY	_____	_____
_____ VASOVASOTOMY	_____	_____
_____ ORCHIDECTOMY	_____	_____
_____ ORCHIOPEXY	_____	_____
_____ TESTICULAR SURGERY	_____	_____
_____ PELVIC LYMPHNODE DISSECTION	_____	_____
_____ MAJOR SURGERY OF PENIS	_____	_____
_____ TRANSURETHRAL RESECTION BLADDER LESION	_____	_____
_____ TRANSURETHRAL VAPORIZATION PROSTATE	_____	_____
_____ TRANSURETHRAL RESECTION PROSTATE	_____	_____
_____ SUPRAPUBIC PROSTATECTOMY	_____	_____
_____ RETROPUBIC PROSTATECTOMY	_____	_____
_____ RADICAL PROSTATECTOMY	_____	_____
_____ CYSTOSTOMY	_____	_____
_____ CYSTECTOMY: PARTIAL/COMPLETE WITH/WITHOUT NODE DISSECTION	_____	_____

<u>PRIVILEGES REQUESTED</u>	<u>APPROX # PERFORMED LAST 2 YEARS</u>	<u>APPROVED AND/OR COMMENTS</u>
_____ ALL URETERAL SURGERY	_____	_____
_____ NEPHRECTOMY - PARTIAL/COMPLETE	_____	_____
_____ ALL KIDNEY SURGERY	_____	_____
_____ ILLEAL CONDUIT	_____	_____
_____ STONE REMOVAL FROM KIDNEY, URETER	_____	_____
_____ CYSTOLITHOLAPAXY	_____	_____
_____ URETEROSCOPY	_____	_____
_____ WITH BIOPSY OF URETER/KIDNEY	_____	_____
_____ WITH STONE REMOVAL	_____	_____
_____ ELECTROHYDRAULIC	_____	_____
_____ LASER	_____	_____
_____ MANIPULATION	_____	_____
_____ LITHOTRIPSY OF STONE	_____	_____
_____ EXCISION SKIN LESIONS - GU AREA	_____	_____
_____ ANTERIOR URETHROPEXY (MARSHALL MARCHETTI)	_____	_____
_____ BURCH, OTHER	_____	_____
_____ VAGINAL APPROACH MODIFIED PYREA	_____	_____
_____ VAGINAL SLING, OTHER	_____	_____
_____	_____	_____
_____	_____	_____

On the basis of my training and experience, I am qualified to exercise and request the privileges which I have checked.

I have not requested privileges for any procedures for which I am not qualified. I am familiar with the laws of the State governing the practice of medicine and pledge to abide by these laws.

PRIVILEGES APPROVED: AS REQUESTED AS MODIFIED BELOW

 Applicant's Signature Date

 Chair, Surgery Department Date