

## Urology

- Appt.
- Reappt.
- Additional/change

PHYSICIAN NAME: \_\_\_\_\_

Date of request: \_\_\_\_\_

Note: Place the appropriate patient age category symbol (s) under the column labeled "requested".  
 "n" = newborns (0-30 days)      "p" - pediatrics (30 days to 14 yrs)      "a" - adults (14 and older)  
*For self taught training: Submit proof of CME*      *For residency - submit residency certificate.*

Clinical Privilege	Requested	Granted <i>(depart chair initials)</i>	Granted with conditions	Number performed last 24 months	TYPE OF TRAINING		ESTIMATED % PAST COMPLICATIONS	
					Residency Fellow	Self Taught	Morbidity	Mortality
Orchiopexy								
Cystoscopy								
Bladder Biopsies								
Female bladder repairs								

I understand that in making this request, I am bound by the applicable Medical Staff Bylaws or policies of the hospital and hereby stipulate that I meet the threshold criteria for each request.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

