

**CARLSBAD MEDICAL CENTER
UROLOGY
APPLICATION FOR PRIVILEGES**

NAME OF APPLICANT: _____

BOARD CERTIFICATION: _____ DATE: _____

Privileges in Urology are granted for both clinical cognitive areas and specific procedures. All practitioners requesting Urology privileges are to be board certified by the American Board of Urology or by the American Osteopathic Board of Urology, or must be fully trained in an accredited Urology residency program recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

CHECK EACH AREA FOR WHICH YOU ARE REQUESTING PRIVILEGES:

R = Requested G = Granted D = Denied

GENERAL COGNITIVE PRIVILEGES

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Admitting Privileges Only |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Admitting and Attending Privileges |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assisting in Surgery Only |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consultation Only |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Critical Care Admission and Management |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trauma Care |

PRIVILEGE LEVEL	PROCEDURAL PRIVILEGES
Level 1	USUAL AND CUSTOMARY UROLOGY PROCEDURAL PRIVILEGES 1) These procedural privileges are usually and customarily performed by board certified, board eligible or fully trained practitioners in Urology; and 2) Documentation of specific training and/or experience in Level 1 procedural privileges may be required; and 3) Level 1 procedural privileges are unasterisked.

PRIVILEGE LEVEL	PROCEDURAL PRIVILEGES
Level 2	ADVANCED UROLOGY PROCEDURAL PRIVILEGES 1) These procedural privileges may be performed by board certified, board eligible or fully trained practitioners in Urology; and 2) Level 2 procedural privileges require documentation of training and experience; and 3) Individual Level 2 procedural privileges must be proctored as defined on this application for privileges form; and 4) Level 2 procedural privileges are denoted by * (one asterisk).

CARLSBAD MEDICAL CENTER –APPLICATION FOR PRIVILEGES – UROLOGY

Name of Applicant: _____

R = Requested G = Granted D = Denied

NOTE: If applying for an asterisked () privilege, enter the number and location of procedures performed in the last 2 years.*

R	G	D		# Performed	Location Performed
ANESTHESIA					
CONSCIOUS SEDATION					
[]	[]	[]	Pediatric (<15 years) Moderate Sedation*	_____	_____
[]	[]	[]	Adult Moderate Sedation*	_____	_____
[]	[]	[]	Pediatric (<15 years) Deep Sedation*	_____	_____
[]	[]	[]	Adult Deep Sedation*	_____	_____
MINOR PROCEDURES					
[]	[]	[]	Cut-Down on Venous Structure		
[]	[]	[]	Excision of Skin Lesion		
[]	[]	[]	Removal of Foreign Body		
[]	[]	[]	I&D of Abscess or Hematoma		
ADRENALS, KIDNEYS AND URETERS					
[]	[]	[]	Adenalectomy*	_____	_____
			Biopsy.		
[]	[]	[]	Kidney		
[]	[]	[]	Ureter		
			Nephrectomy		
[]	[]	[]	Simple		
[]	[]	[]	Radical with Node Dissection*	_____	_____
[]	[]	[]	Nephroureterectomy		
[]	[]	[]	Nephrolithotomy		
[]	[]	[]	Nephrostomy		
[]	[]	[]	Nephrotomy		
[]	[]	[]	Nephrocutaneous Fistula Closure		
[]	[]	[]	Pyeloplasty		
[]	[]	[]	Pyelotomy		
[]	[]	[]	Pyelolithotomy		
[]	[]	[]	Transureteroureterotomy		
[]	[]	[]	Ureterectomy*	_____	_____
[]	[]	[]	Ureterolithotomy		
[]	[]	[]	Ureterolysis		
[]	[]	[]	Ureteroneocystostomy		
[]	[]	[]	Ureteroplasty		
[]	[]	[]	Ureterostomy		
URINARY BLADDER					
[]	[]	[]	Biopsy, Bladder		
CYSTECTOMY					
[]	[]	[]	Simple		
[]	[]	[]	Radical with Node Dissection*		
CYSTOPLASTY					
[]	[]	[]	Augmentation with cecum		
[]	[]	[]	Replacement with intestine		
[]	[]	[]	Cystotomy		
[]	[]	[]	Cystolithotomy		
[]	[]	[]	Vessico-Urethropexy, Marshall Marchetti Kanz		

CARLSBAD MEDICAL CENTER –APPLICATION FOR PRIVILEGES – UROLOGY

Name of Applicant: _____

R	G	D		#	Location Performed
			Performed		
PENIS, SCROTUM AND TESTICLES					
			Biopsy		
[]	[]	[]	Epidymis		
[]	[]	[]	Testis		
[]	[]	[]	Urethra		
[]	[]	[]	Circumcision		
[]	[]	[]	Epididymectomy		
[]	[]	[]	Hydrocelectomy, Scotal		
[]	[]	[]	Hydorelectomy, Communicating with Hernia Repair		
HYPOSPADIAS REPAIR					
[]	[]	[]	Stage One		
[]	[]	[]	Stage Two		
[]	[]	[]	Insertion of Testicular prosthesis		
[]	[]	[]	Insertion of Penile Prosthesis, Semi-rigid		
[]	[]	[]	Insertion of Penile Prosthesis, Inflatable		
[]	[]	[]	Meatotomy with or without Mucosal Advancement		
[]	[]	[]	Orchiopexy for Torsion		
[]	[]	[]	Orchiopexy for Maldescent		
			Orchiectomy		
[]	[]	[]	Simple		
[]	[]	[]	Radical		
			Penectomy		
[]	[]	[]	Partial		
[]	[]	[]	Total		
[]	[]	[]	Seminal Vesiculectomy		
[]	[]	[]	Urethrectomy		
URETHROPLASTY					
[]	[]	[]	One Stage		
[]	[]	[]	Two State		
[]	[]	[]	Transpubic		
[]	[]	[]	Transperineal		
VARICOCELECTOMY					
			Scrotal		
			Inguinal		
			Retroperitoneal		
[]	[]	[]	Vasectomy		
[]	[]	[]	Vasovasostomy		
PROSTATE GLAND					
PROSTATECTOMY					
[]	[]	[]	Suprapubic		
[]	[]	[]	Perineal, Simple		
[]	[]	[]	Perineal, Radical		
[]	[]	[]	Retropubic		
[]	[]	[]	Retropubic, Radical*		
			with Lymph Node Dissection	_____	_____

CARLSBAD MEDICAL CENTER –APPLICATION FOR PRIVILEGES – UROLOGY

Name of Applicant: _____

R	G	D		#	Location Performed
				Performed	
LYMPH NODES					
[]	[]	[]	Lymph Node Biopsy		
NODE DISSECTION					
[]	[]	[]	Aortofemoral*	_____	_____
[]	[]	[]	Iliac-Obturator*	_____	_____
[]	[]	[]	Superficial Inguinal		
[]	[]	[]	Renal and Suprarenal Aortic*	_____	_____
[]	[]	[]	Retroperitoneal*	_____	_____
URINARY DIVERSION					
[]	[]	[]	Ileal Conduit*	_____	_____
[]	[]	[]	Sigmoid Conduit*	_____	_____
[]	[]	[]	Kock Pouch*	_____	_____
[]	[]	[]	Indiana Pouch*	_____	_____
INCIDENTAL GENERAL SURGICAL PROCEDURES					
[]	[]	[]	Appendectomy		
[]	[]	[]	Splenectomy		
[]	[]	[]	Gastrostomy		
INVASIVE MONITORING PROCEDURES					
CENTRAL VENOUS LINE					
[]	[]	[]	Jugular*	_____	_____
[]	[]	[]	Subclavian*	_____	_____
[]	[]	[]	Swan Ganz Catheter Placement*	_____	_____
BASIC ENDOSCOPY					
[]	[]	[]	Cystometrogram		
CYSTOURETHROSCOPY AND/OR WITH					
[]	[]	[]	Ureteral Catheterization		
[]	[]	[]	Stent Placement		
[]	[]	[]	Removal of Foreign Body or Stent		
[]	[]	[]	Crushing and Removal of Calculi		
[]	[]	[]	Ultrasonic or electrohydraulic Lithotipsy of Bladder Calculi		
[]	[]	[]	Bladder Biopsy cold Cup or Resection		
[]	[]	[]	Contigen Implantation		
[]	[]	[]	Transurethral Resection of Bladder Tumor		
[]	[]	[]	Transurethral Resection of Prostate		
[]	[]	[]	Vessicourethropexy (Stamey, Birch, etc.)		
URORADIOLOGY					
[]	[]	[]	Cystogram		
[]	[]	[]	Intravenous Pyelogram		
[]	[]	[]	Retrograde Ureteropyelogram		
[]	[]	[]	Retrograde Urethrogram		
LITHOTRIPSY					
[]	[]	[]	Extracorporeal*	_____	_____

CARLSBAD MEDICAL CENTER –APPLICATION FOR PRIVILEGES – UROLOGY

Name of Applicant: _____

OTHER PROCEDURES

- [] [] [] Specify: _____
- [] [] [] Specify: _____
- [] [] [] Specify: _____
- [] [] [] Specify: _____
- [] [] [] Specify: _____
- [] [] [] Specify: _____
- [] [] [] Specify: _____
- [] [] [] Specify: _____
- [] [] [] Specify: _____
- [] [] [] Specify: _____
- [] [] [] Specify: _____

I certify that I have had the necessary training and experience to perform the procedures that I have requested.

NAME OF APPLICANT (Please Print)

SIGNATURE

DATE

Name of Applicant: _____

APPROVALS

All privilege delineations have been individually considered and have been recommended based upon the practitioner’s specialty, licensure, specific training, experience, health status, current competence and peer recommendations.

APPLICANT MAY PERFORM PRIVILEGES AND PROCEDURES AS INDICATED:

EXCEPTIONS/LIMITATIONS:

(specify)

Surgery Department Chairperson

Date

Medical Staff Executive Committee

Date

Board of Trustees

Date

Name of Applicant: _____

**UROLOGIC SURGERY
CRITERIA FOR CLINICAL PRIVILEGES**

Privileges followed by an asterisk (*) are identified in this table. Please submit required documentation when applicable at the time of appointment or reappointment. The numbers indicated in this table represent the minimal number of documented procedures required to be submitted for consideration of the advanced privilege requested. Additional documentation of training, experience and/or current competence may be requested and additional proctoring may be requested at any time by the Department Chairperson, or the Medical Staff Executive Committee for any privilege requested.

PROCEDURES	TRAINING/EXPERIENCE	Number of Documented Procedures for Initial Appointment	Number of Procedures Every 2 Years	Number of Procedures to be Initially Proctored
ANESTHESIA				
Conscious Sedation – Pediatric (<15 years) Moderate Sedation or Analgesia	See Attachment C	2	1	N/A
Conscious Sedation – Adult Moderate Sedation or Analgesia	See Attachment C	2	1	N/A
Conscious Sedation – Pediatric (<15 years) Deep Sedation or Analgesia	See Attachment C	2	1	4
Conscious Sedation – Adult Deep Sedation or analgesia	See Attachment C	2	1	4
ADRENALS, KIDNEYS, AND URETERS				
Adenectomy	Documentation of Successful Performance	2	1	1
Nephrectomy, Radical with Node Dissection		2	1	1
Ureterectomy		2	1	1
URINARY BLADDER				
Cystectomy – Radical with Node Dissection	Documentation of Successful Performance	2	1	1
PROSTATE GLAND				
Retropubic, Radical with Lymph Node Dissection	Documentation of Successful Performance	2	2	1
LYMPH NODES				
Node Dissection, Aortofemoral	Documentation of Successful Performance	2	1	1
Node Dissection, Iliac-Obturator		2	1	1
Node Dissection, Renal and Suprarenal Aortic		2	1	1
Node Dissection, Retroperitoneal		2	1	1
URINARY DIVERSION				
Ileal Conduit	Documentation of Successful Performance	2	1	1
Sigmoid Conduit		2	1	1
Kock Pouch		2	1	1
Indiana Pouch		2	1	1

CARLSBAD MEDICAL CENTER –APPLICATION FOR PRIVILEGES – UROLOGY

Name of Applicant: _____

PROCEDURES	TRAINING/EXPERIENCE	Number of Documented Procedures for Initial Appointment	Number of Procedures Every 2 Years	Number of Procedures to be Initially Proctored
INVASIVE MONITORING PROCEDURES				
Central Venous Line— Jugular	Documentation of Successful Performance	2	1	1
Central Venous Line— Subclavian		2	1	1
Swan Ganz Catheter	Documentation of Successful Performance	2	1	1
LITHOTRIPSY				
Extracorporeal	Documentation of Successful Performance	2	1	1

Name of Applicant: _____

MEDICAL STAFF CREDENTIALING CRITERIA FOR CONSCIOUS SEDATION

Moderate Sedation or Analgesia

Separate privileges are granted for the categories of adult and pediatric (< 15 years) moderate sedation or analgesia, based on documentation of current competency.

All medical staff requesting any conscious sedation privilege must complete and document a review of the current medical staff conscious sedation policy. **In addition** to the required review of the conscious sedation policy, practitioners requesting privileges in conscious sedation must meet requirements of either #1 **or** #2 listed below:

1. Documentation of training, experience and current competence related to the use of moderate sedation or analgesia, **and** successful performance of at least (1) moderate sedation/analgesia case in the last (2) years for each category of moderate sedation or analgesia applied for and (2) sedation/analgesia cases at initial appointment **OR**
2. Documentation of relevant training and experience **AND**
 - a. Attendance at a Carlsbad Medical Center sponsored CME program on moderate sedation/analgesia **or** review of the videotape of such conference **and** achievement of a score of 85% or higher on the moderate sedation/analgesia post-test, **AND** provisional privileges will be granted pending outcome review.

Deep Sedation or Analgesia

Separate privileges to be granted for the categories of adult and pediatric (< 15 years) deep sedation or analgesia based on documentation of current competency. **All** medical staff requesting any conscious sedation privilege, must complete and document a review of the current medical staff conscious sedation policy **AND** maintain current ACLS certification (*PALS or NALS as appropriate*); **OR** be Board Certified or fully trained in a Carlsbad Medical Center approved residency training program in Emergency Medicine, Anesthesiology or Critical Care Medicine.

In addition to the required review of the conscious sedation policy, ACLS and board certification or residency requirements above, practitioners requesting privileges in conscious sedation must meet requirements of either #1 **or** #2 listed below:

1. Documentation of training, experience and current competence related to use of deep sedation/analgesia, **and** successful performance of at least (1) deep sedation/analgesia cases in the last (2) years for each category of deep sedation or analgesia applied for **OR**
2. Documentation of relevant training and experience, **AND ALL** of the following:
 - a. Attendance at a Carlsbad Medical Center-sponsored CME program on deep sedation/analgesia or review of the videotape of such conference and achievement of the score of 85% or higher on the deep sedation/analgesia post-test, **AND**
 - b. Provide documentation of successful completion of four (4) deep sedation/analgesia cases, in each category applied for, under the direct supervision of a Carlsbad Medical Center practitioner holding appropriate clinical privileges in deep sedation. If applying for both categories of deep sedation/analgesia, a total of six (6) cases will satisfy this requirement **AND**
 - c. Successful completion of four (4) intubations in the Operating Room under the direct supervision of a Carlsbad Medical Center credentialed anesthesiologist. If applying for both categories of deep sedation/analgesia, a total of six (6) cases will satisfy this requirement.

Attachment C



AUTHORIZATION FOR BACKGROUND CHECK

By signing below, I grant permission to the Hospital, its medical staff and representatives ("Hospital") to obtain an investigative report, to include state and federal criminal records and driving arrest records, for purposes of processing my medical staff application. I understand that I may request the Hospital to disclose the nature and scope of the investigation requested within five (5) days of my written request made within a reasonable time after the Hospital obtains the information. I also understand that I am entitled to request a summary of my rights with respect to consumer reporting agencies.

Print Name

Signature

Date