

CLINICAL PRIVILEGES IN GASTROENTEROLOGY AND ENDOSCOPY

Page 1 of 3

Initial

Renewed

Name _____

Effective from ___ / ___ / ___ to ___ / ___ / ___

Applicant: Please initial in the box in the R column for each privilege requested.

R = Requested G = Recommended As Requested C = Recommended with Conditions N = Not Recommended

Note: If Recommendations for clinical privileges are conditional, modified or are not recommended, the specific condition and its reason must be stated where indicated on the last page of this form.

R G C N General Gastroenterology Privileges

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anoscopy (Diagnostic and Therapeutic) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colonoscopy (Diagnostic and Therapeutic) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endoscopic Sclerotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Esophageal Dilation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ERCP, Dilation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Esophageal Stent Placement |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Esophagogastroduodenoscopy wit Dilation, Biopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Esophagoscopy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Flexible Sigmoidoscopy with Biopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Foreign body |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoid Banding |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nonvariceal Hemostasis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Percutaneous Endoscopic Gastrostomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Proctoscopy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pneumatic Dilation Esophagus |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Polypectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Snare Polypectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sigmoidoscopy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper GI Endoscopy, Diagnostic and Therapeutic |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thermal Catherization |

CLINICAL PRIVILEGES IN GASTROENTEROLOGY AND ENDOSCOPY

Page 2 of 3

Initial

Renewed

Name _____

Effective from ___ / ___ / ___ to ___ / ___ / ___

Applicant: Please initial in the box in the R column for each privilege requested.

R = Requested G = Recommended As Requested C = Recommended with Conditions N = Not Recommended

Note: If Recommendations for clinical privileges are conditional, modified or are not recommended, the specific condition and its reason must be stated where indicated on the last page of this form.

R G C N Special Procedures/Techniques

ERBE – Argon Plasma Therapy

R G C N Special Procedures/Techniques

Indicate the types of Laser Equipment/Type of Laser Procedures you would like to perform at the Center:

R G C N Other

- Conscious Sedation
- Anesthesia (Recovery Room Care, Extended)
- Stent Placements (Duodenal, Biliary, Colon)
- Variceal Banding
- Other (Please Specify)

CLINICAL PRIVILEGES IN GASTROENTEROLOGY AND ENDOSCOPY

Page 3 of 3

Initial

Renewed

I have requested only those specific privileges for which my education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at *SSM St. Clare Surgical Center*. I request privileges for the above procedure(s) with the understanding that I consider myself to be in good physical and mental health and I am capable of providing quality care that is acceptable to *SSM St. Clare Surgical Center*.

I verify/confirm that I have am currently privileged to perform the same procedures that I am requesting, above, at a local, Joint Commission Accredited, State licensed, and Medicare approved hospital.

Practitioner Signature

Practitioner Name: Type or Print

Date

Approved by the Credential/Medical Advisory Committee of the Medical Staff and duly appointed to the Medical Staff by the Governing Board.

Medical Director Approval

Date

Governing Board

Date

If Recommendations for clinical privileges are conditional, modified or are not recommended, the specific condition and reason(s) must be stated on this last page and practitioner notified in writing within three days by Administrator and Medical Director.