

CLINICAL PRIVILEGES IN UROLOGY

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 Urology Privileges

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cystoscopy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cystoscopy, with retrograde |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CystoUrethroscopy with or without stent placement |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CystoUrethroscopy for stent removal |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Direct Visual Internal Urethrotomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urethral Dilation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lithotripsy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biopsy, Prostate |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prostactectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Photoselective Vaporization of Prostate |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biopsy, Testicular |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Orchiectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Orchiopexy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hydrocelectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vasovasotomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Testicular Prosthesis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Meatotomy, Urethral |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Plastic Operations on Urethra |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision Hydrocele, Spermatocele |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision Varicocele Spermatic Cord |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision Spermatocele |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epididymectomy |

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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 Urology Privileges, *Continued*

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other Operations Epididymis and vas Deferens |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Circumcision |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Repair Hypospadias |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other Operations of Penis |

R G C N General Urology Privileges

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endoscopy and Endoscopic Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

SSM ST. CLARE SURGICAL CENTER

CLINICAL PRIVILEGES IN UROLOGY

Page 3 of 3

Initial

Renewed

Name _____

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

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.