

# LA CLINICA DE FAMILIA

## OBSTETRIC AND GYNECOLOGY REQUEST FOR PRIVILEGES

General Requirements: Physicians requesting Obstetric and Gynecology privileges will have successfully completed an OB/GYN residency in a program accredited by the ACGME or the AOA, and be board certified or board eligible.

Provider's Name: \_\_\_\_\_

Request	Verified	Approved	Not Approved	PROCEDURES AND SERVICES	Request	Verified	Approved	Not Approved	PROCEDURES AND SERVICES
				Admitting, attending, and consulting privileges in an in-patient setting					Hymenotomy
				Perform history and physical examination: To include pap smear and STD screening					Wide local excision of the vulva
				Interpretation of laboratory data					Vaginectomy
				Cardiopulmonary resuscitation (basic life support)					Pessary fitting
				Provide family planning counseling					Prenatal care
				Insert and remove IUD's					Diagnose breast disease, treat and/or make appropriate referral
				Fit diaphragms					Non-stress testing
				Prescribe hormonal contraception					
				Diagnose and treat pelvic infections					
				Perform wet prep testing					
				Treatment of Condylomata with cryotherapy, TCA, and/or excision					
				Perform biopsy of the vulva, vagina, cervix, and endometrium					
				Excision of vulvar, vaginal, and cervical lesions					
				Perform colposcopy of the cervix, vagina, and vulva					
				Incision and drainage of vulvar abscess					
				Cervical polypectomy					
				Perform paracervical blocks					
				Suture of lacerations					
				Apply and change wound dressing					
				Diagnose and treat pelvic infections					
				Marsupialization of Bartholin gland abscess and cyst					
				Cone Biopsy of the cervix					
				Loop electrosurgical excision procedure					
				Dilatation and curettage					
				Hysteroscopy					
				Laparoscopy; diagnostic, operative, and for tubal ligation					
				Exploratory laparotomy					
				Perineorrhaphy					

Documentation of training and expertise to perform all practice procedures requested must be provided.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_ Temporary Approval pending Medical/Dental Staff Committee Meeting

\_\_\_\_ Denied

\_\_\_\_\_  
Signature Medical Director

\_\_\_\_\_  
Date

**Medical/Dental Staff Committee Approval**

\_\_\_\_ Temporary Approval (temporary employees)

\_\_\_\_ Regular Approval

\_\_\_\_ Regular Provisional Approval

\_\_\_\_ Approval with modifications (specify below)

\_\_\_\_ Denied (specify below)

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\_\_\_\_\_  
Medical/Dental Staff Committee Chairperson

\_\_\_\_\_  
Date