

**WEST JEFFERSON MEDICAL CENTER**  
**Marrero, Louisiana**  
**PRIVILEGE REQUEST FORM FOR GASTROINTESTINAL ENDOSCOPY**

**Minimum threshold criteria**

*To be eligible to use this form to request clinical privileges, the following minimum threshold criteria must be met.*

1. *Basic education:* M.D. or D.O.
2. *Minimum formal training:* The applicant must be able to demonstrate successful completion of an approved fellowship/residency training program in gastroenterology, gastrointestinal surgery, or colorectal surgery.
3. *Additional training requirement:* If not taught in an approved fellowship/residency training program, the applicant must have completed a hands-on training program for each procedure requested through a preceptorship or proctorship under the supervision of an experienced endoscopist.
4. *Required previous experience:* For each procedure requested the successful applicant must be able to demonstrate that he or she has had the following minimal endoscopic experience in the last 12 months:

- diagnostic EGD-75 procedures
- total colonoscopy-75 procedures
- snare polypectomy-20 procedures
- nonvariceal hemostasis (upper and lower); includes 10 active bleeders- 20 procedures
- variceal hemostasis; includes five active bleeders-10 procedures
- esophageal dilation with guide wire-5 procedures
- flexible sigmoidoscopy-25 procedures
- PEG-10 procedures
- ERCP (diagnostic)-20 procedures
- ERCP (therapeutic)- 10 procedures
- tumor ablation-10 procedures
- pneumatic dilation for achalasia-5 procedures
- esophageal stent emplacement-5 procedures

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**References:**

An applicant's endoscopic training director(s) should confirm in writing the training, experience (including the number of cases for each procedure for which privileges are requested), and actually observed level of competency.

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**Reappointment:**

Reappointment will be based on unbiased, objective results of care according to the hospital's quality assurance mechanisms. The applicant must demonstrate that he or she has maintained competence in each procedure requested by requiring on an annual basis the performance of the same number of procedures listed above for initial appointment.

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*I understand that in making this request I am bound by West Jefferson Medical Center's applicable bylaws and policies. I hereby stipulate that I meet the threshold criteria for each request.*

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Physician's signature

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Typed or printed name

Approved: 4/97

Date

**"In general, core privileges consist of those areas listed above. The medical staff may modify or limit the privileges granted."**