

MILLARD FILLMORE SURGERY CENTER, LLC

Name _____

Date _____

DELINEATION OF PRIVILEGES – UROLOGY

Credentialing period effective for 2 years

ADULT (patients >18yrs.) LEVEL I (CORE) PRIVILEGES <i>Applicant must have completed an ACGME-Accredited Residency in Urology or its Equivalent</i>				
Cystoscopy		Hydrocelectomy		
Biopsy and/or Fulguration of Bladder Tumor		Spermatocectomy		
Bladder Irrigation		Vasectomy		
Biopsy of Prostate and/or Bladder		Orchidopexy		
Ureteral Catherterization		Excision of Skin Lesions		
Vasovasotomy		Laser of Skin Lesions		
Spermatic Vein Ligation (Varicocelectomy)		Lymph node biopsy		
Internal Urethrotomy		Biopsy of Testes, e.g. infertility		
Penile Prosthesis Placement – Semi Rigid		Administration of local anesthesia		
Circumcision		History and Physical		
<u>ADULT LEVEL I (CORE) PRIVILEGES</u>	PHYSICIAN REQUEST	Granted	Not Granted*	With Following Requirements** (Provide Details)
PEDIATRIC LEVEL I (CORE) PRIVILEGES <i>Applies to children 18 months to 18 years of age (except for circumcision). Applicant must have completed an ACGME-Accredited Residency in Urology or its Equivalent</i>				
Orchidopexy		Meatotomy		
<u>PEDIATRIC LEVEL I (CORE) PRIVILEGES</u> <i>Applies to children 18 months to 18 years of age (except for circumcision).</i>	PHYSICIAN REQUEST	Granted	Not Granted*	With Following Requirements** (Provide Details)
<u>ADULT LEVEL II PRIVILEGES</u>	PHYSICIAN REQUEST	Granted	Not Granted*	With Following Requirements** (Provide Details)

KEY	**WITH FOLLOWING REQUIREMENTS
*NOT GRANTED DUE TO: Provide Details Below	Provide Details Below
1) Lack of Documentation	1) With Consultation
2) Lack of Required Training/Experience	2) With Assistance
3) Lack of Current Competence (Databank Reportable)	3) With Proctoring
4) Other (Please Define) (i.e., Exclusive Contract)	4) Other (Please Define)

DETAILS: _____

National Practitioner Databank Disclaimer Statement:

Kaleida Health must report to the National Practitioner Data Bank when any clinical privileges are not granted for reasons related to professional competence or conduct. (Pursuant to the Health Care Quality Improvement Act of 1986 (43 U.S.C. 11101 et seq.)

Signature of Applicant _____ Date _____

Signature of Clinical Chief _____ Date _____

APPLICANT: PLEASE RETAIN A COPY OF THIS SIGNED DELINEATION FOR YOUR RECORDS