

MILLARD FILLMORE SURGERY CENTER, LLC

Name _____

Date _____

DELINEATION OF PRIVILEGES GYNECOLOGY

Credentialing period effective for 2 years

<u>LEVEL I (CORE) GYNECOLOGY PRIVILEGES</u> <i>Applicants for Level I privileges have successfully completed residency training in an ABOG approved obstetrics and gynecology residency program. The following procedures are included at this level.</i>
Administration of local anesthesia
Breast Biopsy
Cervical Biopsy/Polypectomy
Cervical Cone Biopsy
Cervical Conization (CO2 laser ablation and cone biopsy)
Colporrhaphy, anterior
Colporrhaphy, posterior
Colporrhaphy, combined anterior/posterior
Colporrhaphy with enterocele repair
Colposcopy
Colpotomy
Diagnostic Laparoscopy (open or closed)
Dilatation and Curettage (D&C)
Exam under Anesthesia (EUA)
Excision of Bartholin Cyst
Excision of Vaginal Cyst/Tumor
Fallopian Tube Ligation by Laparoscopy
Fulguration Condylomata

<u>LEVEL I (CORE) GYNECOLOGY PRIVILEGES (CON'T)</u>
History and Physical
Hymenotomy, Hymenectomy
Hysteroscopy-Minor Asherman's Syndrome
Hysteroscopy – Removal of IUD
I&D of Abscess (site specific)
Laparoscopic Bilateral Tubal Occlusion
Laser CO2- lower genitals, hymen and cervix
LEEP Procedure
Mini Laparotomy (Sterilization Only)
Missed Abortion ≤ weeks by suction
Operative Laparoscopy
Perineoplasty
Soft Tissue/Skin Excisional & Incisional Biopsy
Spontaneous Abortion
Trachelectomy/Cervicectomy
Vulvar or Vaginal Biopsy

<u>LEVEL I (CORE) GYNECOLOGY PRIVILEGES</u>	PHYSICIAN REQUEST	Granted	Not Granted*	With Following Requirements* (Provide Details)

<u>LEVEL II GYNECOLOGY PRIVILEGES</u> <i>Requires evidence of satisfactory education and training</i>	PHYSICIAN REQUEST	Granted	Not Granted*	With Following Requirements* (Provide Details)
Bladder Botox Injection				
Clitoral hoodoplasty				
Cysto-Urethroscopy/Cystoscopy				
Labioplasty: labia majora				
Labioplasty: labia minora				
Removal or revision of sling for stress incontinence				
Revision of prosthetic vaginal graft				
Sling operation for stress incontinence				
Urethral Bulking				
Vaginoplasty				

LEVEL II GYNECOLOGY PRIVILEGES * Requires evidence of satisfactory training ** Requires a prerequisite of hysteroscopy privileges and evidence of satisfactory training in operative hysteroscopy	PHYSICIAN REQUEST	Granted	Not Granted*	With Following Requirements** (Provide Details)
Operative Hysteroscopy Surgical Privileges -Requires completion of an approved didactic program experience usually obtained by a course in Operative Hysteroscopy approved for AMA Category 1 credits or ACOG Cognates for each procedure requested or Documentation of training in Operative Hysteroscopy in an accredited residency program for each procedure requested and include date and name of institution where training was completed -Have you been supervised by a member of any Gynecologic Endoscopic Surgery Committee in the performance of at least five (5) cases specific for each procedure you are requesting? YES _____ NO _____ - IF YES, ATTACH A LIST, including patient name, procedure, and supervisor, as well as, a signed statement from the preceptor indicating that you have participated in the specified number of cases and are ready to perform the requested procedure independently. "Grandfathering" will be considered for current attending based on a recent case list.				
**Operative hysteroscopy				
Endometrial Ablation by Electrocautery				
Major Asherman's Syndrome				
Removal of Fibroid/Polyp				
Resection of Submucous Fibroid				
Thermal Balloon Ablation				
Microtubal Anastomosis				

KEY	*NOT GRANTED DUE TO: Provide Details Below	**WITH FOLLOWING REQUIREMENTS 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 (42 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