Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_________________________________ _______________________
Print Name Date

Privilege Request Form - Urology

SECTION I – GENERAL REQUIREMENTS UROLOGY

Requested Staff Category

______ Active _______ Courtesy _______ Consulting ________ Affiliate

Basic Education: MD or DO

INITIAL APPOINTMENT

Minimal formal training and experience

- Successful completion of an ACGME-accredited urology residency program or clinical fellowship training program or an AOA- approved training program in urology.
- The number of cases performed in the last 12 months for each procedure requested along with the documentation of proficiency referenced above, must be sufficient to validate competence. An applicant who has just completed a residency shall provide his/her residency log. Additional documentation and monitoring may be required at the discretion of the Medical Director or the Chief of Staff. Some procedures may require additional documentation of training and experience which is acceptable to the Medical Director such as Proctoring Reports, Operative Reports and Discharge Summaries for other institutions, written communication of documents from the Chairperson of the designee of an approved academic training program, approved continuing medical education course, or clinical department from another institution attesting to completion of a specified course of training, and/or the number of the specified successful procedures performed, and/or the applicants known ability to perform a specific procedure for which the applicant has previously been formally trained to carry out in an approved program.
- Member in good standing of an accredited acute care hospital and/or ambulatory surgery center, with the same or similar unrestricted privileges.
- Evidence of Certification by the American Board of Urology, American Osteopathic Board of Urology is preferred.
- Interview by the Medical Director and/or Chief of Staff when requested.

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For Advanced Endoscopy

- Privileges for the corresponding open procedure; AND
- Previous operative experience, documentation of experience (operative reports) adequate to justify the privileges being requested; OR
- For those without previous operative experience, an advanced laparoscopic surgery course with animate, hands-on training and experience serving as a first assistant or documentation of training with an experienced surgeon.
- The first two (2) patient cases may be proctored by an experienced surgeon, skilled in the procedure.

REAPPOINTMENT MAINTENANCE OF PRIVILEGE

- Demonstrated evidence of clinical activity from relevant professional practice evaluation during the past 24 months without significant quality variations, OR
- Peer recommendations when performance data is insufficient at the time of reappraisal; and
- Ongoing maintenance of continuing medical education as it pertains to scope of license and specialty.

SECTION II – PRIVILEGES REQUESTED

Core Procedures	Requested	Granted	Denied
Admit Patients			
Perform H & P			
Provide consultation to determine need for surgical intervention			
Order diagnostic studies & procedures			
Order medications			
Post-surgical evaluation and treatment			
Medical management of post-surgical patients using prudent and good medical judgment for appropriate consultation			

Surgical Procedures	# Procedures in last 12 months	Requested	Granted	Denied

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Circumcision				
Cystourethroscopy				
Cystourethroscopy with retrograde x ray				
Excision penile lesion				
Hernia repair associated with cord or testicular surgery				
Laser lithotripsy				
Ureterosopy diagnostic				
Ureteroscopy with removal of stone & laser lithotripsy				
Laser removal of superficial genital lesions				
Laser prostatectomy PVP (photo vaporization prostate) or indigo				
Removal residual kidney stones via existing nephrostomy tract with or without laser lithotripsy				
Transurethral microwave therapy				
Electro hydraulic lithotripsy				
Meatotomy				
Laproscopic Variocele				
Meatoplasty				
Repair hypospadius •				
Cystolithotomy				
Inguinal hernia repair when incidental to orchiopexy				
Reconstructive surgery of urinary & genital tract				
Repair & plastic operation on penis				
Surgery of testicle, epididymis, vas deferens				
Lithotripsy Procedure				
Ultrasound Bx-Prostate				
Cystotomy for exc bladder divert (s/p)				
Cystourethroscopy with urethrotomy female				
Cystourethroscopy rem f.b. or stents (s/p)				
Cystourethroscopy with dilation of urethra				
Cystourethroscopy with biopsy				
Cystourethroscopy with removal of foreign body				
Cystourethroscopy (separate procedure)				

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Cystourethroscopy with fulguration				
Cystourethroscopy with urethrotomy male				
Exc of penile plaque (Nesbitt procedure)				
Insertion of penile prosthesis				
Transurethral resection bladder neck (s/p)				
Transperineal needle localization				
Fluoroscopy (certificate required)				

If you anticipate administering your own anesthesia, please complete the Moderate Sedation Privilege Request Form

SECTION III - ACKNOWLEDGMENT OF PRACTITIONER:

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at the Hospital. I hereby attest that the references, reports, records, and information are available that verify my qualifications and competency to practice urological surgery or any other special privileges I have requested and to perform the requested procedures.

I understand that:

1. In exercising any clinical privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
2. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.
3. The use of any other new, untried, or unproven procedure/treatment modality/instrumentation may be performed or used only after the regular credentialing process has been completed and the privilege to perform or use said procedure/treatment modality/instrumentation has been granted to the individual practitioner.

____________________________________ ____________________________
PHYSICIAN SIGNATURE DATE

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_________________________________ ______________________
Print Name Date

Recommendation of the Medical Director:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

______ Approval of all requested privileges

______ Approval of the following privileges with conditions:
____

______ Denial of the following privileges:
____

_______________________________________ ______________________
Medical Director **Date**

Recommendation of the Medical Executive Committee:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

______ Approval of all requested privileges

______ Approval of the following privileges with conditions:
____

______ Denial of the following privileges:
____

_____________________________________ ______________________
Chief of Staff **Date**

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______________________________ ____________________

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Decision of the Governing Board:

The Governing Board has reviewed the above recommendations regarding the requested clinical privileges and supporting documentation for the above named applicant and has:

______Granted all requested privileges

______Granted the following privileges with conditions:
____

_____ Denied the following privileges:
____

____ ________________________________

Chairman of the Board **Date**