Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

OBSTETRICAL AND GYNECOLOGY CORE PRIVILEGES

Criteria: Completion of an ACGME or AOA approved Obstetrics and Gynecology Residency training program, **AND** either Board Certified or Active Candidate for certification by the American Board of Obstetrics and Gynecology, **OR** meet the requirements of Section 1.3.1 of the Medical Staff Rules and Regulations. New residency graduates will be given up to 24 months following completion of the residency training program to become Active Candidates for Certification.

Proctoring Requirements: A minimum of six (6) cases under direct observation, unless specified that retrospective proctoring is acceptable, in accordance with the specific procedures outlined below:

OB CORE: Two vaginal deliveries (retrospectively proctored) and one Cesarean-Section

GYN CORE: One abdominal hysterectomy; one major vaginal procedure; one procedure other than a D&C

GYN ONCOLOGISTS A minimum of four cases under the Gyn Core privilege listing to include one minor procedure and three major procedures (with one procedure being a vaginal procedure)

REPRODUCTIVE ENDOCRINOLOGY/INFERTILITY: A minimum of four cases under the Gyn Core privilege listing to include one minor procedure and three major procedures.

CONSULT ONLY PRIVILEGES: A minimum of six (6) consultation cases.

GENERAL PRIVILEGES

Privilege	Requested	Deferred	Approved
Obstetrical Admitting Privileges	___	___	___
Gynecology Admitting Privileges	___	___	___
Surgical Assist Privileges ONLY Includes surgical assisting in obstetrical or gynecological surgery procedures only. Physicians granted "Surgical Assist Privileges Only" do NOT have privileges to admit patients, perform consultations, provide care independently, perform medical History and Physical Examinations, prescribe medications or to perform surgical or invasive procedures as the primary operator.	___	___	___
Consultation Privileges ONLY Includes privileges to perform consultations for obstetrical or gynecological patients ONLY. Physicians granted "Consultation Privileges ONLY" do NOT have privileges to admit patients, provide care independently, perform medical History and Physical Examinations, write orders, prescribe medications, perform surgical or invasive procedures or to assist with surgical or invasive procedures.	___	___	___

Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Sedation Analgesia ***Criteria:*** Requires successful completion of the Sedation Assessment Test ***Additional criteria effective April 1, 2015:*** a) Evidence of current ACLS and/or PALS certification from the American Heart Association; AND b) Evidence of completion of an Airway Management Course	___	___	___
a) Adult Sedation	___	___	___
b) Pediatric Sedation (17 years and under)	___	___	___
OBSTETRICAL CORE PRIVILEGES Includes the management and coordination of care, treatment and services, including: Medical history and physical examinations, consultations and prescribing medication in accordance with DEA certificate.	___	___	___
Breast Feeding Management (One-time privileging) ***Criteria***: Requires successful completion of approved Breast Feeding course/test. Confirmation of previous completion is acceptable.	___	___	___
Management of normal labor, including the following types of deliveries:	___	___	___
a) Vacuum assisted	___	___	___
b) Low forceps	___	___	___
c) Mid forceps	___	___	___
d) Version extraction	___	___	___
e) Cesarean Section	___	___	___
Destructive procedures (procedures greater than 20 weeks gestation requires consultation)	___	___	___
Cerclage: Abdominal (Requires consultation with a Maternal/Fetal Medicine specialist)	___	___	___
Cerclage: Vaginal	___	___	___

Huntington Hospital

Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Amnio infusions	___	___	___
Internal fetal monitoring	___	___	___
Sampling of fetal scalp blood	___	___	___
Circumcision	___	___	___
Management of premature rupture of membranes and premature labor and delivery.	___	___	___
Treatment of complications of pregnancy, including the following:	___	___	___
a) Pregnancy-induced hypertension	___	___	___
b) Chronic hypertension	___	___	___
c) Diabetes mellitus	___	___	___
d) Renal disease	___	___	___
e) Coagulopathies	___	___	___
f) Cardiac disease	___	___	___
g) Anemias and hemoglobinopathies	___	___	___
h) Thyroid disease	___	___	___
i) Sexually transmitted disease	___	___	___
j) Pulmonary disease	___	___	___
k) Thromboembolic disorders	___	___	___
l) Infectious disease	___	___	___
m) Breech presentation	___	___	___

Huntington Hospital

Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Amniocentesis: Second and Third trimester	___	___	___
Obstetrical ultrasound	___	___	___
Antepartum oxytocin challenge test	___	___	___
External version of breech	___	___	___
Management of abnormal presentation of fetus:	___	___	___
a) Breech Cesarean-section	___	___	___
b) Classical	___	___	___
c) Low cervical transverse	___	___	___
d) Low cervical vertical	___	___	___
Induction of labor with oxytocin	___	___	___
Augmentation of labor with oxytocin	___	___	___
Multiple pregnancy	___	___	___
Cesarean hysterectomy	___	___	___
Management of postpartum complications:	___	___	___
a) Severe anemia	___	___	___
b) Severe infection	___	___	___
c) Severe hemorrhage	___	___	___
Hypogastric artery ligation	___	___	___
Management of intrauterine fetal demise	___	___	___
Administration of fetal lung maturity inducers	___	___	___

Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Management of high-risk pregnancy inclusive of:	___	___	___
a) Pre-eclampsia	___	___	___
b) Post-dates	___	___	___
c) Third trimester bleeding	___	___	___
d) Intrauterine growth retardation	___	___	___
Vaginal Birth after Cesarean-section (VBAC)	___	___	___
Fetal Heart Tracing Reading ***Criteria:*** Requires Competency Testing at appointment and reappointment.	___	___	___
GYNECOLOGY CORE PRIVILEGES Includes the management and coordination of care, treatment and services, including: Medical history and physical examinations, consultations and prescribing medication in accordance with DEA certificate.	___	___	___
Cerclage: Abdominal	___	___	___
Dilatation and Curettage (D&C)	___	___	___
Incision and drainage of Bartholin cyst or perineal abscess (ACC)	___	___	___
Incision and drainage of breast abscess	___	___	___
Cervical biopsy and vulvar biopsy (ACC)	___	___	___
Marsupialization of Bartholin cyst	___	___	___
Pap smear (ACC)	___	___	___
Laparotomy	___	___	___
Abdominal and Vaginal Operation for removal of:	___	___	___
a) Uterus	___	___	___

Huntington Hospital

Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
b) Cervix	___	___	___
c) Oviducts	___	___	___
d) Ovaries	___	___	___
e) Appendix	___	___	___
Operation for urinary stress incontinence:	___	___	___
a) Vaginal approach	___	___	___
b) Retropubic urethral suspension	___	___	___
Fistula repair: Recto-vaginal	___	___	___
Hernia repair: incisional and umbilical	___	___	___
Operation for non-invasive carcinoma of:	___	___	___
a) Vulva	___	___	___
b) Vagina	___	___	___
c) Uterus	___	___	___
d) Ovary	___	___	___
e) Cervix	___	___	___
Repair of rectocele, enterocele, cystocele	___	___	___
Coloplasty	___	___	___
Colpocleisis	___	___	___
Myomectomy	___	___	___
Incidental appendectomy	___	___	___

Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Cystoscopy	___	___	___
Hysterosalpingography	___	___	___
Proctoscopy	___	___	___
Sacro-spinous ligament vaginal suspension	___	___	___
Management of ectopic pregnancy and other accidents of pregnancy (missed, incomplete or complete abortion)	___	___	___
D & C on pregnant uterus less than 12 weeks gestational size	___	___	___
D & C for molar pregnancy	___	___	___
Metroplasty	___	___	___
Treatment of Aschermann's syndrome	___	___	___
Colposcopy (ACC)	___	___	___
Culdoscopy	___	___	___
Cystectomy	___	___	___
Conization of cervix	___	___	___
Lysis of adhesions:	___	___	___
a) Intra-abdominal "Free-hand use"	___	___	___
b) Microscopically directed	___	___	___
Oncologic debulking procedures (Intra-abdominal "free-hand use")	___	___	___
Adnexal surgery (including ectopic pregnancy, tubal ligation, oophorectomy, salpingectomy or tuboplasty)	___	___	___
Loop electrosurgical excision procedures (LEEP)	___	___	___

Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Excisional biopsy of superficial breast or axillary lesion, which may be performed under the following limited circumstances: Lesion is documented as non-malignant by mammography, ultrasound, or fine-needle aspiration; lesion is superficial	___	___	___
Laparoscopy:	___	___	___
a) Diagnostic	___	___	___
b) Tubal sterilization	___	___	___
c) Fulguration of lesions of ovary, pelvic viscera or peritoneal surface	___	___	___
d) Lysis of adhesions	___	___	___
e) Biopsy of peritoneal surface(s)	___	___	___
f) Aspiration	___	___	___
g) Removal of foreign body (e.g. IUD)	___	___	___
h) Oophorectomy	___	___	___
i) Ovarian cystectomy	___	___	___
Hysteroscopy:	___	___	___
a) Diagnostic	___	___	___
b) Directed biopsy or polypectomy	___	___	___
c) Lysis of intrauterine adhesions	___	___	___
Treatment of ectopic pregnancy	___	___	___
Ovarian Cystectomy	___	___	___
Oophorectomy	___	___	___

Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Salpingectomy	___	___	___
Myomectomy	___	___	___
Appendectomy	___	___	___
Operative hysteroscopy to include: Septal incision, myomectomy, endometrial ablation, any method	___	___	___

OBSTETRICS AND GYNECOLOGY SUPPLEMENTAL PRIVILEGES

Criteria:

a) Must meet the criteria outlined for Core Obstetrical and Core Gynecology privileges; **AND**
b) Provide documentation of competency from residency program director for each privilege requested; **OR**
c) Provide documentation of completion of an ACGME or AOA approved Obstetrics and Gynecology sub-specialty fellowship training program.

Privilege	Requested	Deferred	Approved
Supplemental OBSTETRICAL Privileges ***Proctoring Requirements:*** A minimum of one case from each letter defined in category "a" through "c".	___	___	___
a) Extraperitoneal Cesarean Section	___	___	___
b) Periumbilical Blood Sampling	___	___	___
c) Transabdominal amnio infusion using criteria. ***Criteria:*** 2nd trimester amniocentesis ability	___	___	___

Supplemental GYNECOLOGY Privileges

Proctoring Requirements: A minimum of one case from each letter defined in category "a" through "f".

Privilege	Requested	Deferred	Approved
a) Operation for urinary stress incontinence: sling procedure	___	___	___
b) Fistula repair: Vesico-vaginal	___	___	___
c) LASER THERAPY for cervix, vagina, vulva, perineum - **colposcopically directed**: (select laser types 1, 2, and/or 3 below)	___	___	___

Provider Name:

Privilege	Requested	Deferred	Approved
1) ARGON/KTP	___	___	___
2) C02	___	___	___
3) Nd: YAG	___	___	___
d) LASER THERAPY for cervix, vagina, vulva, perineum - **free hand**: (select laser types 1, 2, and/or 3 below)	___	___	___
1) ARGON/KTP	___	___	___
2) C02	___	___	___
3) Nd: YAG	___	___	___
e) ARGON beam coagulator therapy - **free hand**	___	___	___
f) ARGON beam coagulator therapy - **endoscopic**	___	___	___

Supplemental GYNECOLOGIC ONCOLOGY Privileges
Proctoring Requirements: A minimum of one case from each letter defined in category "a" through "g".

Privilege	Requested	Deferred	Approved
a) Ureterovaginal fistula	___	___	___
b) Radical Trachelectomy	___	___	___
c) Treatment of malignant disease with chemotherapy to include gestational Trophoblastic disease	___	___	___
d) Radical hysterectomy for treatment of invasive carcinoma of cervix	___	___	___
e) Radical surgery for treatment of gynecological malignancy to include procedures on bowel, ureter, bladder, as indicated	___	___	___
f) Treatment of invasive carcinoma of vulva by radical vulvectomy and reconstruction with split thickness or pedicle graft	___	___	___

Provider Name:

Privilege	Requested	Deferred	Approved
g) Treatment of invasive carcinoma of the vagina by radical vaginectomy and reconstruction with split thickness or pedicle graft.	___	___	___
h) Node dissection	___	___	___
i) Standard CHEMOTHERAPY Privileges ***Proctoring Requirements:*** A minimum of one case from each of the following:	___	___	___
1) Intraperitoneal Therapy	___	___	___
2) Chemotherapy via SQ access port	___	___	___
Supplemental REPRODUCTIVE ENDOCRINOLOGY/INFERTILITY ***Proctoring Requirements:*** A minimum of one case from each letter defined in category "a" through "c".	___	___	___
a) Gamete/Zygote intrafallopian transfer **(requires support staff)**	___	___	___
b) Techniques of IVF, including transabdominal/transvaginal ova **(requires support staff)**	___	___	___
c) Microsurgical tubal operations:	___	___	___
1) Salpingolysis/salpingoplasty/salpingotomy	___	___	___
2) Tubal anastomosis	___	___	___
3) Tubal reimplantation	___	___	___

Supplemental LAPAROSCOPIC Privileges

Criteria: Current staff members may provide certification of completion of a CME approved laparoscopic training program/course in the specific privilege requested. Physicians must currently be privileged for analogous "open" procedures.
Proctoring Requirements: A minimum of one case from each letter defined in category "a" through "c".

Privilege	Requested	Deferred	Approved
Supplemental LAPAROSCOPIC Privileges:	___	___	___

Provider Name:

Privilege	Requested	Deferred	Approved
a) Laparoscopic operative procedures to include: 1) Myomectomy 2) Laparoscopic assisted vaginal hysterectomy (LAVH) 3) Neosalpingostomy/fimbrioplasty 4) Laparoscopic Supercervical hysterectomy (LSH) 5) Laparoscopic hysterectomy (LH)	___	___	___
b) Laparoscopic operative procedures to include: 1) Vaginal vault suspension 2) Uterine suspension 3) Cystourethropexy	___	___	___
c) Laparoscopic radical procedures to include: 1) Laparoscopic radical hysterectomy with retroperitoneal pelvic lymph node sampling 2) Total pelvic lymphadenectomy 3) Periaortic lymph node sampling 4) Presacral neurectomy	___	___	___

Supplemental ROBOTIC ASSISTED LAPAROSCOPIC Privileges - *(REQUIRES REVIEW BY THE ROBOTIC COMMITTEE CHAIR)*

Criteria: Applicants must be Board Certified or qualified for certification by the American Board of Obstetrics and Gynecology. Must have current Supplemental (advanced) laparoscopic privileges and open privileges in the specific procedure being requested. Must provide documentation of course attendance, training or experience in basic laparoscopy. Must provide documentation/certification of completion of training for Robotic Assisted Minimally Invasive Surgery with Intuitive Surgical da Vinci Surgical System Training Program, AND meet one of the following:

ROUTE 1: Requires previous practice experience via an accredited residency or fellowship program with documented clinical experience of a minimum of twenty (20) robotic assisted procedures with at least ten (10) as the primary.
Proctoring Requirement - ROUTE 1: At least the first three (3) cases as the primary surgeon (one case from each letter defined category "a" through "c". If proctoring in "c" first, physicians do not have to be proctored in "a" or "b".), proctored by two different surgeons who have performed a minimum of ten (10) robotic procedures.
Competency Requirement - ROUTE 1: Performance of at least five (5) robotic procedures per year to maintain robotic privileges. Physicians who fails to meet the competency requirements will be required to undergo proctoring of at least three (3) cases.

Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

ROUTE 2: Completion of an approved residency or fellowship program in the surgical specialty. The physician must maintain Supplemental (advanced) laparoscopy privileges.
Proctoring Requirement - ROUTE 2: At least the first five (5) cases as the primary surgeon (one case from each letter defined category "a" through "c". If proctored in "c" first, physicians do not have to be proctored in "a" or "b".), proctored by two different surgeons who have performed a minimum of ten (10) robotic procedures.
Competency Requirement - ROUTE 2: Performance of at least five (5) robotic procedures per year to maintain robotic privileges. Physicians who fail to meet the competency requirements will be required to undergo proctoring of at least five (5) cases.

Supplemental ROBOTIC ASSISTED LAPAROSCOPIC Procedures

a) Robotic-assisted Laparoscopic operative procedures to include: ___ ___ ___
    1) Laparoscopic assisted vaginal hysterectomy (LAVH)
    2) Neosalpingostomy/fimbrioplasty
    3) Laparoscopic Supercervical hysterectomy (LSH)
    4) Laparoscopic hysterectomy (LH)

b) Robotic-assisted Laparoscopic operative procedures to include: ___ ___ ___
    1) Vaginal vault suspension
    2) Uterine suspension
    3) Cystourethropexy
    Criteria: Applicants for this privilege must hold Robotic assisted laparoscopic operative procedures as outlined in "a" above.

c) Robotic-assisted Laparoscopic Radical Procedures to include: ___ ___ ___
    1) Laparoscopic radical hysterectomy with retroperitoneal pelvic lymph node sampling
    2) Total pelvic lymphadenectomy
    3) Periaortic lymph node sampling
    4) Presacral neurectomy

Revised: 04/27/2006; 09/28/06; 10/26/06; 05/12/09; 9/23/10; 01/24/2013; 05/23/2013; 02/27/14; 10/30/2014

Delineation Of Privileges

Obstetrics and Gynecology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

ACKNOWLEDGEMENT OF THE PRACTITIONER:
I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at Huntington Hospital, and I understand that: a) in exercising my clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation; b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature of Applicant: ____________________________________ Date:____________________________

DEPARTMENT CHAIR RECOMMENDATIONS

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Applicant may perform privileges and procedures as indicated: ______ YES ______ NO

Exceptions/Limitations (Please Specify): ____

APPROVALS:

Robotic Chair: ____ Date: ___________________

Department Chair _______________________________________ Date: ___________________

Credential Committee Date: __________

Medical Executive Committee Date: __________

Board of Directors Approved on: __________