Harris Methodist Southlake Center for Diagnostics & Surgery

Core Privileges in Urology

Name: ____

Please indicate with a check mark the privileges requested.

Qualifications
To be eligible for core privileges in urology, the applicant must meet the following qualifications:

- Demonstration of the performance of at least 50 urological surgical procedures in the past two years or successful completion of a hospital-affiliated formalized residency or clinical fellowship;

and

- Current certification or active participation in the examination process leading to certification in urological surgery by the American Board of Urology or the American Osteopathic Board of Surgery; or
- Successful completion of an ACGME- or AOA-accredited residency in urology, during which at least 3 years were devoted to urological surgery.

_____ Privileges included in the core
Privileges to admit, evaluate, diagnose, and provide treatment in a consultative role to patients of all ages—except where specifically excluded from practice and except for those special procedures listed below—presenting with genitourinary conditions.

- catheter placement
- dilation of urethral strictures
- Operation for treatment of urinary stress incontinence; vaginal approach, retropubic urethral suspension

Special procedures privileges
To be eligible for special procedure privileges below, the applicant must demonstrate experience of performing the procedure within the past two (2) years, consistent with the criteria set forth here. Case lists must identify the patient name or medical record number, date of procedure, location where procedure

Procedure	Criteria	Requested	Recommended	Not Recommended

****If the procedure that you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and experience.**

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at **Harris Methodist Southlake**, and

I understand that:
(a) In exercising any 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.

Signed: ____

Date: ____

Credentials Committee Recommendations: _____ Recommend _____Deny

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

Signed: ____

Date: ____

Recommended/Not recommended with the following modification(s) and reason(s):

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