Harris Methodist Southlake
Center for Diagnostics and Surgery

Core Privileges in Gynecology

Name: ____

Please indicate with a check mark the privileges requested.

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

- Demonstration of the performance of at least 100 gynecologic 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 obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology; or
- Successful completion of an ACGME- or AOA-accredited residency in obstetrics and gynecology.

_____ **Privileges included in the core**
Privileges to admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care necessary to correct or treat female patients of all ages presenting with illnesses, injuries, and disorders of the gynecological or genitourinary system and non-surgical treatment of illnesses and injuries of the mammary glands, except for those special procedure privileges listed below.

- Cervical biopsy Cervical biopsy
- Colpoeleisis
- Colpoplasty
- Colposcopy, LEEP procedures, cone biopsy
- Diagnostic D&C
- Diagnostic hysteroscopy
- Diagnostic laparoscopy
- Endometrial Ablation with the Uterine Balloon or similar technology
- Endometrial Ablation or myomectomy/polypectomy with the Resectoscope
- Evacuation of molar pregnancy
- Hymenotomy
- Hysterectomy, abdominal, vaginal
- Hysterosalpingography
- I&D of Bartholin cyst or perineal abscess
- I&D of pelvic abscess
- Incidental appendectomy

- Laparoscopic surgery including adhesiolysis, destruction of superficial endometriosis, ovarian biopsy, cyst puncture, cystectomy, salpingo-oophorectomy, laparoscopic assisted vaginal hysterectomy, myomectomy and tubal sterilization
- Marsupialization of Bartholin cyst
- Metroplasty
- Myomectomy
- Operation for treatment of urinary stress incontinence; vaginal approach, retropubic urethral suspension
- Operations for treatment of benign pelvic disease; D&C with conization, laparotomy, adhesiolysis, abdominal hysterectomy, vaginal hysterectomy, salpingectomy, oophorectomy
- Ovarian cystectomy
- Repair of rectocele, enterocele, cystocele
- Sterilization tubal procedure, open or laparoscopic
- Repair of vaginal prolapse, abdominal or vaginal approach
- Tubal plastic procedures including reananstomosis
- Vesicovaginal fistula, rectovaginal fistual repair
- Vulvar biopsy
- Vulvectomy, simple

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
Diagnostic Ultrasound/ Gyn	5			
Operative Hysteroscopy	5			
Laparoscopic assisted supracervical hysterectomy (LASH)	3			

****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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