CORE SURGICAL PRIVILEGES FORM / PEDIATRIC SURGERY

Applicant's Name: .....

License No. (If Any): ..... Date: D D M M Y Y Y Y

CATEGORY I: GENERAL PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. I & D of body abscesses excluding perianal	☐		☐	☐	
2. Lymph node biopsy excluding neck region	☐		☐	☐	
3. Excision biopsy of subcutaneous lumps	☐		☐	☐	
4. Circumcision >60 days of age	☐		☐	☐	
5. Neonate circumcision < 60 days of age	☐		☐	☐	
6. Meatotomy	☐		☐	☐	
7. Excision of periauricular sinus/cyst	☐		☐	☐	
8. Excision of thyroglossal duct	☐		☐	☐	

CATEGORY II: ABDOMINAL SURGERY

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Umbilical hernia repair	☐		☐	☐	
2. Inguinal hernia repair for a child over 2 years	☐		☐	☐	
3. Inguinal hernia repair for a child under 2 years	☐		☐	☐	
4. Surgery for congenital hydrocele	☐		☐	☐	
5. Surgery for undescended testis (palpable)	☐		☐	☐	
6. Pyloromyotomy	☐		☐	☐	
7. Appendectomy	☐		☐	☐	
8. Supra umbilical hernia/ epigastric hernia repair	☐		☐	☐	
9. Rectal suction biopsy	☐		☐	☐	

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Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
10. Proctoscopy & sigmoidoscopy	☐		☐	☐	
11. Rectal polypectomy	☐		☐	☐	

CATEGORY III: NEONATAL SURGERY (ABDOMINAL)

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Rectal suction biopsy	☐		☐	☐	
2. Excision of chest wall swelling	☐		☐	☐	

Note:
You must submit along with this application all necessary document(s) to support your request.

Applicant's signature ..... Date: D D M M Y Y Y Y

CORE SURGICAL PRIVILEGES FORM / PEDIATRIC SURGERY

FOR COMMITTEE USE ONLY

Committee Decision:

Evaluation type:

- By Interview ☐ virtual / personal
- By documents only ☐
- Or both ☐

Other comments:

.....

We have reviewed the requested clinical privileges and supporting documentation for the above-named applicant, and We have made the above-noted recommendation(s).

Clinical privileging committee members:

.....
Name, Signature & Stamp

Date: DD MM YYYY

.....
Name, Signature & Stamp

Date: DD MM YYYY

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Name, Signature & Stamp

Date: DD MM YYYY

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Date: DD MM YYYY

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Name, Signature & Stamp

Date: DD MM YYYY