CORE SURGICAL PRIVILEGES FORM / GASTROENTEROLOGY

Applicant's Name: .....

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

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Diagnostic Oesophago-Gastro-Duodenoscopy and biopsy (OGD)	☐		☐	☐	
2. Diagnostic ileo-colonoscopy and biopsies	☐		☐	☐	
3. Polypectomy for colonic polyp < 1 cm or pedunculated polyp > 1 cm with a stalk of < 1 cm	☐		☐	☐	
4. Capsule endoscopy	☐		☐	☐	
5. Endoscopic management of upper and lower G.I. bleeding	☐		☐	☐	
6. PEG (Percutaneous Endoscopic Gastrostomy)	☐		☐	☐	
7. Luminal dilatation	☐		☐	☐	

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

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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

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Name, Signature & Stamp

Date: DD MM YYYY

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Name, Signature & Stamp

Date: DD MM YYYY

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