ADVANCED SURGICAL PRIVILEGES FORM / OBSTETRICS AND GYNECOLOGY

Applicant's Name: .....

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

CATEGORY I: OUTPATIENT PROCEDURE

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Office Hysteroscopy *	☐		☐	☐	

CATEGORY II: LABOR ROOM PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Breech extraction	☐		☐	☐	
2. Breech assisted delivery	☐		☐	☐	
3. Internal podalic version	☐		☐	☐	
4. Twin delivery	☐		☐	☐	
5. External cephalic version	☐		☐	☐	
6. Forceps delivery (non-rotational)	☐		☐	☐	
7. Vacuum assisted delivery	☐		☐	☐	
8. Deinfibulation of FGM in labor	☐		☐	☐	

CATEGORY III: OB/GYN PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Cervical cerclage vaginal procedures	☐		☐	☐	
2. Lower segment caesarean section	☐		☐	☐	
3. Classical C/section & hysterotomy in pregnancy	☐		☐	☐	
4. Examination under anesthesia (other than for suspected malignancy)	☐		☐	☐	
5. Evacuation of the product of conception	☐		☐	☐	

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Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
6. Insertion of Uterine Balloon	☐		☐	☐	
7. Repair of 3rd degree tear	☐		☐	☐	
8. Repair of 4th degree tear	☐		☐	☐	
9. Caesarean hysterectomy	☐		☐	☐	
10. B-Lynch sutures and other hemostatic sutures	☐		☐	☐	
11. Surgical management of placenta previa	☐		☐	☐	
12. Surgical management of morbidly adherent placenta	☐		☐	☐	
13. Repair of ruptured uterus	☐		☐	☐	
14. Incision/excision of hymen	☐		☐	☐	
15. Anterior vaginal repair	☐		☐	☐	
16. Posterior vaginal repair +/-perineorrhaphy	☐		☐	☐	
17. Total abdominal hysterectomy +/- bilateral salpingo-oophorectomy (including sub-total hysterectomy)	☐		☐	☐	
18. Laparotomy Oophorectomy / ovarian cystectomy	☐		☐	☐	
19. Laparotomy Salpingectomy/salpingostomy	☐		☐	☐	
20. Laparotomy myomectomy	☐		☐	☐	
21. Vaginal hysterectomy +/- salpingo-oophorectomy	☐		☐	☐	
22. Diagnostic hysteroscopy *	☐		☐	☐	
23. Diagnostic laparoscopy +/- sterilization	☐		☐	☐	
24. Repair of enterocoele	☐		☐	☐	
25. Endometrial ablation procedure (specify)	☐		☐	☐	
26. Hysteroscopic resection of fibroids/septae	☐		☐	☐	
27. Manchester repair	☐		☐	☐	
28. Laparotomy Tubal Reconstruction/ Anastomosis	☐		☐	☐	
29. Ventro-suspension (abdominal laparotomy)	☐		☐	☐	
30. Fenton Repair- Perineal body reconstruction	☐		☐	☐	

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Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
31. Le Fort procedure	☐		☐	☐	
32. Vulval/vaginal reconstructive plastic procedures	☐		☐	☐	
33. Bilateral salpingo-oopherectomy (Risk Reduction Surgery - RRS)	☐		☐	☐	
34. Ovarian transposition	☐		☐	☐	
35. Vulvar reconstruction (Vulvoplasty)	☐		☐	☐	
36. Colposcopy	☐		☐	☐	
37. Vulvoscopy +vaginoscopy	☐		☐	☐	
38. Laser ablation of preinvasive disease of vulva / vagina / cervix	☐		☐	☐	
39. Large Loop Excision of the Transformation Zone (LLETZ) for preinvasive cervical disease *	☐		☐	☐	

CATEGORY IV: FETOMATERNAL MEDICINE PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Detailed anomaly scan (level 3)	☐		☐	☐	
2. Fetal Wellbeing screening and assessment (general)	☐		☐	☐	
3. Dating and NT scan	☐		☐	☐	
4. Fetal anomaly scan	☐		☐	☐	
5. Amniocentesis	☐		☐	☐	
6. Percutaneous Fetal Intrauterine Transfusion (IUT)	☐		☐	☐	
7. Chorion Villus Sampling (CVS)	☐		☐	☐	
8. Cordocentesis	☐		☐	☐	
9. Amnio reduction	☐		☐	☐	
10. Fetal reduction	☐		☐	☐	

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CATEGORY V: ASSISTED REPRODUCTION PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Intra-uterine insemination	☐		☐	☐	
2. Oocyte retrieval (transvaginal/ transabdominal)	☐		☐	☐	
3. Laparoscopic oocyte retrieval or embryo transfer	☐		☐	☐	
4. Transvaginal intra-uterine embryo transfer	☐		☐	☐	
5. Transvaginal aspiration of ovarian cysts	☐		☐	☐	
6. Transvaginal aspiration of ascitic fluid	☐		☐	☐	

CATEGORY VI: LAPAROSCOPIC PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Laparoscopically assisted vaginal hysterectomy +/- oophorectomy	☐		☐	☐	
2. Laparoscopic oophorectomy or ovarian cystectomy	☐		☐	☐	
3. Laparoscopic salpingectomy or salpingostomy sterilization	☐		☐	☐	
4. Laparoscopic adhesiolysis	☐		☐	☐	
5. Laparoscopic ovarian drilling	☐		☐	☐	
6. Laparoscopic ablation of endometriosis	☐		☐	☐	
7. Laparoscopic transection of uterosacral nerve	☐		☐	☐	
8. Laparoscopic hysterectomy	☐		☐	☐	
9. Laparoscopic myomectomy	☐		☐	☐	
10. Dissection/excision of severe endometriosis including deep pelvic nodules	☐		☐	☐	
11. Laparoscopic removal of intrauterine contraceptive device / Filshie Clip	☐		☐	☐	

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CATEGORY VII: UROGYNAECOLOGY PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Urodynamic studies *	☐		☐	☐	
2. Vaginal repairs involving the use of meshes	☐		☐	☐	
3. Laparotomy vault / uterine suspension using mesh	☐		☐	☐	
4. Laparoscopic vault suspension using mesh	☐		☐	☐	
5. Laparoscopic uterine suspension using mesh	☐		☐	☐	
6. Abdominal or laparoscopic uterosacral suspension	☐		☐	☐	
7. Laparoscopic colposuspension	☐		☐	☐	
8. Rectus fascial sling	☐		☐	☐	
9. Sacro-spinous fixation	☐		☐	☐	
10. Injection of urethral bulking agents	☐		☐	☐	
11. Sacro-colpopexy	☐		☐	☐	
12. Burch (or modified) colposuspension	☐		☐	☐	
13. Urethral dilatation	☐		☐	☐	
14. Cystoscopy *	☐		☐	☐	
15. Botox injection to bladder wall	☐		☐	☐	
16. Cystoscopic ureteric catheter insertion	☐		☐	☐	
17. Excision of urethral or bladder diverticulum	☐		☐	☐	
18. Insertion of suprapubic catheter	☐		☐	☐	
19. Tibial/sacral nerve stimulation	☐		☐	☐	

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CATEGORY VIII: GYNAECOLOGY SUB-SPECIALTY PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Diagnostic/second look laparoscopy and biopsy	☐		☐	☐	
2. Fertility sparing surgery (unilateral salpingo-oopherectomy) and staging biopsies	☐		☐	☐	
3. Radical hysterectomy	☐		☐	☐	
4. Radical vulvectomy	☐		☐	☐	
5. Modified radical vulvectomy	☐		☐	☐	
6. Wide local vulvar excision (Simple vulvectomy)	☐		☐	☐	
7. Groin lymph node dissection	☐		☐	☐	
8. Pelvic/para-aortic and groin node dissection	☐		☐	☐	
9. Omentectomy	☐		☐	☐	
10. Pelvic exenteration (Anterior/Posterior)	☐		☐	☐	
11. Laparoscopic lymphadenectomy	☐		☐	☐	
12. Incidental omental biopsy	☐		☐	☐	
13. Trachelectomy	☐		☐	☐	

CATEGORY IX: OTHER PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Robotic surgery **Please specify:**	☐		☐	☐	
2. Newborn Male Circumcision	☐		☐	☐	
3. Obs/Gyn related bladder injury repair	☐		☐	☐	
4. Obs/Gyn related bowel Injury repair	☐		☐	☐	
5. Transabdominal/Transvaginal Drainage of Pelvic abscess	☐		☐	☐	

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Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
6. Internal iliac artery ligation in postpartum hemorrhage	☐		☐	☐	
7. Abdominal cerclage	☐		☐	☐	
8. Removal of abdominal cerclage	☐		☐	☐	
9. Symphysiotomy	☐		☐	☐	
10. Fetal Destructive Procedures	☐		☐	☐	
11. Caesarean scar Niche Surgery	☐		☐	☐	
12. Surgical Management of scar pregnancy	☐		☐	☐	

ADDITIONAL PRIVILEGE (NOT INCLUDED ABOVE)

Privileges	For applicant use		For committee use				
	Request	Signature	Recommended			Not Recommended	Reason for rejection (if any)
			Facility type				
			Hospital	Day care	Clinic under LA		

* Should be done in procedure room only not in the Doctor clinic room

Note:

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

Applicant's signature ..... Date: DD MM YYYY

ADVANCED SURGICAL PRIVILEGES FORM / OBSTETRICS AND GYNECOLOGY

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).

.....
Name, Signature & Stamp

Date: DD MM YYYY

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Name, Signature & Stamp

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