CORE SURGICAL PRIVILEGES FORM /OBSTETRICS AND GYNECOLOGY

EXCLUDING HIGH RISK PREGNANCY

Applicant's Name: .....

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

CATEGORY I: OUTPATIENT PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Basic Transabdominal Obstetric ultrasound examination (fetal presentation, number of fetuses viability & placental localization) *	☐		☐	☐	
2. Basic neonatal resuscitation	☐		☐	☐	
3. Endometrial sampling **	☐		☐	☐	
4. Prescribing of Clomiphene citrate	☐		☐	☐	
5. Prescribing of GnRH agonists for abnormal vaginal bleeding only (NOT for fertility treatment)	☐		☐	☐	
6. Removal of cervical polyp	☐		☐	☐	
7. Pelvic examination **	☐		☐	☐	
8. Taking of cervical smear and vaginal/ cervical/urethral swabs	☐		☐	☐	
9. Insertion and removal of vaginal pessaries	☐		☐	☐	
10. Insertion/removal of intrauterine contraceptive device	☐		☐	☐	
11. Insertion of Hormonal Replacement Therapy (HRT) implant	☐		☐	☐	
12. Insertion/ removal of subdermal contraceptive implant (such as Implanon/Norplan implants) *	☐		☐	☐	
13. Cryocautery of cervix	☐		☐	☐	
14. Manual Vacuum Aspiration (MVA)	☐		☐	☐	
15. Transvaginal obstetric ultrasound examination*	☐		☐	☐	

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CATEGORY II: LABOR ROOM PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Induction/augmentation of labor	☐		☐	☐	
2. Interpretation of Cardiotocographs (CTG's)	☐		☐	☐	
3. Artificial rupture of membranes	☐		☐	☐	
4. Application of fetal scalp electrode	☐		☐	☐	
5. Normal vaginal delivery	☐		☐	☐	
6. Cord blood collection for stem cell reservation	☐		☐	☐	
7. Episiotomy and repair	☐		☐	☐	
8. Repair of 1st and 2nd degree tears	☐		☐	☐	
9. Removal of cervical cerclage	☐		☐	☐	
10. Fetal blood sampling	☐		☐	☐	
11. Skin biopsy from Intra Uterine Fetal Death (IUFD)	☐		☐	☐	

CATEGORY III: OB/GYN PROCEDURES

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Manual Removal of Placenta	☐		☐	☐	
2. Repair of cervical tear	☐		☐	☐	
3. Dilatation and curettage/removal of products of conception	☐		☐	☐	
4. Excision of vulva / vaginal lesions	☐		☐	☐	
5. Incision and drainage of vulval abscess / hematoma	☐		☐	☐	
6. Marsupialization + drainage & drainage of bartholin abscess	☐		☐	☐	

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CATEGORY IV: ASSISTED REPRODUCTION PROCEDURES

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

* Completion of Training course is mandatory

** 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: 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

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