Surgical Privileges Form:
Pediatric Surgery (Core Privileges)

Clinical Privileges Request

Applicant's Name: ..... Scope of Practice: .....

License No. (If Any): ..... Facility: .....

Date: .....

Core Privileges

Category I: General Procedures

Privileges	Requested (To be completed by the applicant)	Recommended (For committee use)		Not Recommended (For committee use)
		Under Supervision	Independent	
1. I & D of body abscesses excluding perianal				
2. Lymph node biopsy excluding neck region				
3. Lymph nodes biopsy neck region				
4. Excision biopsy of subcutaneous lumps				
5. Circumcision				
6. Meatotomy				

Category II: Abdominal Surgery

Privileges	Requested (To be completed by the applicant)	Recommended (For committee use)		Not Recommended (For committee use)
		Under Supervision	Independent	
1. Umbilical hernia repair				
2. Surgery for omphalomesentric remnants				
3. Inguinal hernia repair for a child over 2 years				
4. Inguinal hernia repair for a child under 2 years				
5. Surgery for congenital hydrocele				
6. Surgery for undescended testis (palpable)				
7. Pyloromyotomy				
8. Appendectomy				
9. Surgery for intestinal obstruction past the neonatal period				
10. Umbilical hernia repair				
11. Rectal suction biopsy				
12. Proctoscopy & Sigmoidoscopy				

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13. Rectal polypectomy				

Note: You must submit along with this application all necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.

By signing below, I acknowledge that I have read, understand, and agree to abide by QCHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

a) In exercising any clinical privileges granted, I am constrained by QCHP's 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 situation my actions are governed by the recognized policies and rules.

…….. ……
Applicant's signature (Stamp if any) Date

1. …….. ……
Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signatur Date

For Committee use only

Evaluation Committee Chairman:

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

…….. ……
Chairperson's Stamp & signature Date

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Other Committee Members:

…….. ……

1) Name Date

…….. ……

2) Name Date

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