APPLICANT NAME: _____

GASTROENTEROLOGY SURGERY

I hereby request surgical privileges in the specialty of Gastroenterology as shown in this form. I understand that privileges granted are subject to a bi-annual review coinciding with reapplication for medical staff membership. I also understand that application for additional or new procedures can be made at any time with proper documentation.

Please indicate with an "X" in the appropriate box and by signature at the end of this document the procedures you are requesting privileges for.

Applied for	**APPROVAL**	
❑ Esophagastroduodenoscopy (EGD)	❑ YES	❑ NO
❑ EGD with biopsy	❑ YES	❑ NO
❑ EGD with cauterization	❑ YES	❑ NO
❑ Colonoscopy	❑ YES	❑ NO
❑ Colonoscopy with polypectomy	❑ YES	❑ NO
❑ EGD with ligation of varices	❑ YES	❑ NO
❑ EGD with foreign body removal	❑ YES	❑ NO
❑ EGD with balloon dilation	❑ YES	❑ NO
❑ EGD with Savary dilation	❑ YES	❑ NO
❑ EGD with Maloney dilation	❑ YES	❑ NO
❑ EGD with tumor ablation	❑ YES	❑ NO
❑ EGD with PEG placement	❑ YES	❑ NO
❑ EGD with polypectomy	❑ YES	❑ NO
❑ PEG change	❑ YES	❑ NO
❑ Colonoscopy through stoma	❑ YES	❑ NO
❑ Colonoscopy with biopsy	❑ YES	❑ NO
❑ Colonoscopy with polypectomy	❑ YES	❑ NO
❑ Colonoscopy with decompression	❑ YES	❑ NO
❑ Colonoscopy with foreign body removal	❑ YES	❑ NO
❑ Colonoscopy with hemostasis	❑ YES	❑ NO
❑ Colonoscopy with stricture dilation	❑ YES	❑ NO
❑ Anoscopy	❑ YES	❑ NO
❑ Liver biopsy	❑ YES	❑ NO
❑ Parascentesis	❑ YES	❑ NO
❑ Enteroscopy	❑ YES	❑ NO
❑ Sigmoidoscopy with biopsy	❑ YES	❑ NO
❑ Sigmoidoscopy with polypectomy	❑ YES	❑ NO
❑ Sigmoidoscopy with decompression	❑ YES	❑ NO

❑ Sigmoidoscopy with foreign body removal	❑ YES	❑ NO
❑ Sigmoidoscopy with hemostasis	❑ YES	❑ NO
❑ Sigmoidoscopy with stricture dilation	❑ YES	❑ NO
❑ EGD with botox injection	❑ YES	❑ NO
❑ EGD with epinephrine injection	❑ YES	❑ NO
❑ Radiography Use of Modality & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Ultrasound Use of Modality & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Fluoroscopy Use of Modality with State License & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO
❑ Local anesthesia	❑ YES	❑ NO
❑ Conscious Sedation	❑ YES	❑ NO
❑ Supervision of Conscious Sedation Trained Registered Nurse	❑ YES	❑ NO
OTHERS NOT LISTED		
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

Signature of Applicant _____ Date _____

Signature of QI Committee Chairperson _____ Date _____

Signature of Governing Body Chairperson _____ Date _____