

**DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
& DEPARTMENT OF FAMILY AND PREVENTIVE MEDICINE**

CHECKLIST FOR EXPANDED PRIVILEGES IN OBSTETRICS FOR FAMILY MEDICINE PHYSICIANS: INITIAL REQUEST

TO BE COMPLETED BY THE DEPARTMENT OF FAMILY AND PREVENTIVE MEDICINE

Family Physician: _____

Date of Application: _____

Application Includes:

- Submission of privilege form requesting expanded services. Yes__ No__
- Documentation of number of expanded services by type and Hospital/Clinic (names, dates and medical records). Yes__ No__
- Two discharge summaries (Gestational Diabetes, Suspected IUGR, Hemorrhage during Cesarean section requiring transfusion, other complex perinatal case). Yes__ No__
- Two Letters of Reference. Yes__ No__
- Proof of current ALSO Certification. If not certified, when will certification be completed? _____ Yes__ No__

Letters of Reference included in packet form:

Name _____
Specialty _____
City _____ State _____
Hospital _____
Phone Number () _____

Name _____
Specialty _____
City _____ State _____
Hospital _____
Phone Number () _____

Note:

☐ Credentialing is based upon each individual physician's documented training and experience, demonstrated abilities, and current competence. Application for obstetrical and gynecological privileges with the family physician acting as the principle surgeon will be reviewed primarily by the Department of Family and Preventive Medicine. At the direction of the Chairman of OB-GYN, a period of proctoring to include a minimum of six (6) procedures may be required for all surgical privileges requested before these privileges are granted. Such proctoring may be waived at the discretion of the Chairman of OB-GYN if sufficient direct knowledge of the competency of the individual may already be known.

Created: 2004
 Revised: 8/8/07

Quantitative Requirements:

Procedure	Minimum Required	Requesting	Achieved [Dept Completes]
Cesarean sections excluding abnormal implantation, past multigestation, >32 weeks	75	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cesarean section, placenta previa	10	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Incomplete abortion or missed abortion	3	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Cesarean section	10	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Non-reassuring fetal heart rate tracing in labor	10	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Severe preeclampsia or eclampsia	10	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
D & C <13 weeks	10	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Postpartum tubal ligation	10	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Forceps, low	7	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gestational diabetes mellitus	10	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes mellitus, Type-1 or Type-2	10	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Malpresentation in labor: breech, brow or face	Requires Cesarean section privileges	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Preterm labor, tocolysis <36 weeks	10	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
PROM, <36 weeks	10	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
External Cephalic Version	5	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Multiple gestation	5	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cervical incompetence	5	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Labor disorders protracted or arrest	5	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Serious cardiac, renal, collagen-vascular or hematologic co-disorders	To be determined	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Molar pregnancy	To be determined	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intrauterine fetal growth restriction (ultrasound confirmed)	To be determined	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal antepartum fetal surveillance	To be determined	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cervical lacerations	To be determined	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Minimum qualitative requirements (circle the appropriate response;
please add comments on back of page):

Reference	Poor Excellent					Not Applicable
	1	2	3	4	5	
Technical competency & skill in operative procedures	1	2	3	4	5	N/A
Medical judgment	1	2	3	4	5	N/A
Capability to handle complications	1	2	3	4	5	N/A
Adequate number of procedures as primary surgeon	1	2	3	4	5	N/A
Availability to address medical problems	1	2	3	4	5	N/A
Ability to anticipate or prevent complications	1	2	3	4	5	N/A

Request for Expanded Privileges:

Recommended as requested

Recommend for selected requests (some requested procedures denied; list of _____ and reasons for denials are detailed on separate page)

All requests denied for reasons stated on separate page

Signature
Chair, Department of Obstetrics and Gynecology

Date

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