Surgical Privileges Form:
Pediatric Surgery (Core Privileges)

Clinical Privileges Request

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

License No. (If Any): …… Facility: ……

Date: ……

Core Privileges

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommen -ded*	*Not Recommended*	*Signature*

Category I: General Procedures

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

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					
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.
- Granting privileges under supervision is no longer permitted

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

Other Committee Members:

…….. ……
1) Name Date

…….. ……
2) Name Date