

DELINEATION OF PRIVILEGES  
 PRACTICE AREA: **GYNECOLOGY**

To request these clinical privileges, the following threshold criteria must be met:

1. Licensed by the State of Iowa as M.D. or D.O., **AND**
- 2a. Board Certification by the American Board of Obstetrics & Gynecology or the American Osteopathic Board of Obstetrics & Gynecology, **OR**
- 2b. Successful completion of an ACGME or AOA accredited residency program in obstetrics & gynecology **WITH** board certification in 5 years or less of residency completion. **AND**
3. Maintain admitting obstetrics & gynecology privileges at one of the UnityPoint Health-Des Moines Hospitals, one of the Mercy Health Network-Des Moines Hospitals, VA Central Iowa Health Care System or Broadlawns Medical Center. Surgeons with VA privileges only will be limited to schedule adult patients only at the center.

**GYNECOLOGY PRIVILEGES - I am requesting gynecology surgery privileges for:**

Requested	Granted	
<input type="checkbox"/>	<input type="checkbox"/>	Correct or treat female patients of all ages presenting with illnesses, injuries, and disorders of the gynecologic and uro-gynecological systems
<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy – diagnostic / operative
<input type="checkbox"/>	<input type="checkbox"/>	Colposcopy / Hysteroscopy – diagnostic / operative
<input type="checkbox"/>	<input type="checkbox"/>	Endometrial ablation
<input type="checkbox"/>	<input type="checkbox"/>	Exploration / Debridement / Excision / Biopsy of soft tissue, skin or nodes of the female pelvis and related structures
<input type="checkbox"/>	<input type="checkbox"/>	Dilation and Curettage
<input type="checkbox"/>	<input type="checkbox"/>	Intra-operative Repair of minor bowel or bladder injuries / Appendectomy
<input type="checkbox"/>	<input type="checkbox"/>	TOT / TVT slings
<input type="checkbox"/>	<input type="checkbox"/>	Myomectomy (open)
<input type="checkbox"/>	<input type="checkbox"/>	Tubal reanastomosis
<input type="checkbox"/>	<input type="checkbox"/>	Use of Laser
<input type="checkbox"/>	<input type="checkbox"/>	Administration of local anesthesia
<input type="checkbox"/>	<input type="checkbox"/>	Administration of minimal sedation
<input type="checkbox"/>	<input type="checkbox"/>	Supervision of Allied Health Practitioner/Residents/Students

**SPECIAL PROCEDURES/TECHNIQUES**

To be eligible to apply for the special procedure listed below, you must meet the above threshold criteria and you **must also** demonstrate successful completion of an approved, recognized course, or acceptable supervised training in residency, fellowship or other acceptable experience and provide documentation of competence in performing that procedure.

Requested	Granted	
<input type="checkbox"/>	<input type="checkbox"/>	Neurostimulation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Periurethral injection of bulking agents

To admit patients, perform histories and physicals, order diagnostic tests, request consultations, provide consultations within the scope of your privileges, use all skills normally learned during medical school and residency and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the facility.

You are expected to practice within the bounds of your training and competence and should not attempt to treat cases, which are not in your scope of practice. Newly developed treatment modalities are not included in this request and must be cleared by the Medical Executive Committee and Governing Board before their performance. Please become familiar with the capabilities and limitations of this facility.

I understand that in making this request I am bound by the applicable bylaws and/or policies of Lakeview Surgery Center and hereby stipulate that I meet the threshold criteria for this request. I also certify that I have knowledge to operate all the equipment necessary to carry out requested procedures.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Applicant's Name Printed

**Privileges:**

Granted \_\_\_\_\_ Deferred \_\_\_\_\_

\_\_\_\_\_  
MEC Signature Date

Granted \_\_\_\_\_ Deferred \_\_\_\_\_

\_\_\_\_\_  
GB Signature Date

Modifications: \_\_\_\_\_