

Jersey City Medical Center
Medical-Dental Staff Office

Dear Doctor:

RE: **REQUEST OF CLINICAL PRIVILEGES**

Attached is a Delineation of Privileges form to request clinical privileges in the Department of Obstetrics and Gynecology. Please review, place a check corresponding to each privilege that you wish to request and affix your signature approval.

In addition, we ask that you please provide documentation of the number and types of procedures you have performed within the past year at the hospital(s) where you are most clinically active.

Thank you.

**Jersey City Medical Center
Delineation Of Privileges**

Provider:
Department/Specialty: GYNECOLOGY

| Code | Privilege | Reqstd (check) | Dept Review | Board Approvd |
|------|---|-------------------|----------------|------------------|
| 022 | Uterine suspension | _____ | _____ | _____ |
| 023 | Pre-sacral neurectomy | _____ | _____ | _____ |
| 024 | Marshall-Marchetti pubo-vesico urethral susp. | _____ | _____ | _____ |
| 025 | Hysterectomy, radical, wertheim | _____ | _____ | _____ |
| 026 | Exenteration, complete | _____ | _____ | _____ |
| 027 | Exenteration, anterior | _____ | _____ | _____ |
| 028 | Salpingectomy | _____ | _____ | _____ |
| 029 | Tubal repair | _____ | _____ | _____ |
| 030 | Tubal implantation into uterus | _____ | _____ | _____ |
| 031 | Tubal Sterilization | _____ | _____ | _____ |
| 032 | Oophorectomy | _____ | _____ | _____ |
| 033 | Hypogastric Aa. ligation | _____ | _____ | _____ |
| 034 | Appendectomy | _____ | _____ | _____ |
| 035 | Hymenotomy | _____ | _____ | _____ |
| 036 | Incompetent Os surgery | _____ | _____ | _____ |
| 037 | Repair surgical rent. of bladder, bowel | _____ | _____ | _____ |
| 038 | Ureteral, repair | _____ | _____ | _____ |
| 039 | Ureteral, transplant | _____ | _____ | _____ |
| 040 | Incisional hernia repair | _____ | _____ | _____ |
| 041 | Fundectomy | _____ | _____ | _____ |
| 042 | Salpingostomy | _____ | _____ | _____ |
| 043 | Skin grafting | _____ | _____ | _____ |
| 044 | Urethral caruncle-fulgaration | _____ | _____ | _____ |
| 045 | Umbilical hernia repair | _____ | _____ | _____ |
| 046 | LaForte vaginal repair | _____ | _____ | _____ |
| 047 | Manchester-Fothergill Operation | _____ | _____ | _____ |
| 048 | Repair/recto-vaginal fistula | _____ | _____ | _____ |
| 049 | Repair/vesico-vaginal fistula | _____ | _____ | _____ |

Current Status Codes:

D - Denied
N - Not Requested

L - Limitations/Conditions
A - Approved

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|------|--|-------------------|----------------|------------------|
| 050 | Sturmdorf repair of cervix | _____ | _____ | _____ |
| 051 | Ilyestero salpingogram | _____ | _____ | _____ |
| 052 | Heckel's diverticulum | _____ | _____ | _____ |
| 053 | Wedge resection of ovaries | _____ | _____ | _____ |
| 054 | Ilydated mole evacuation | _____ | _____ | _____ |
| 055 | Tubal implantation into uterus | _____ | _____ | _____ |
| 056 | Closure of vaginal vesico vaginal | _____ | _____ | _____ |
| 057 | Evacuation of pelvic abcesses | _____ | _____ | _____ |
| 058 | Dehiscence repair | _____ | _____ | _____ |
| 059 | Evisceration repair | _____ | _____ | _____ |
| 060 | Colpectomy | _____ | _____ | _____ |
| 061 | Plastic construction of vagina with skin graft for congenital abcess | _____ | _____ | _____ |
| 062 | Colpectomy-exploratory | _____ | _____ | _____ |
| 063 | Removal of foreign body from vagina & uterus | _____ | _____ | _____ |
| 064 | Culdoscopy | _____ | _____ | _____ |
| 065 | Ectopic pregnancy | _____ | _____ | _____ |
| 066 | Colpotomy | _____ | _____ | _____ |
| 067 | Colposcopically directed biopsy of cervix | _____ | _____ | _____ |
| 068 | Hymenectomy | _____ | _____ | _____ |
| 069 | Salpingoplasty | _____ | _____ | _____ |
| 070 | Cystostomy, suprapubic | _____ | _____ | _____ |
| 071 | Insertion of cysto cath. | _____ | _____ | _____ |
| 072 | Laparoscopy | _____ | _____ | _____ |
| 073 | Laparoscopy-Diagnostic | _____ | _____ | _____ |
| 074 | Laparoscopy-Tubal sterilization | _____ | _____ | _____ |
| 075 | Laparoscopy-Biopsy | _____ | _____ | _____ |
| 076 | Microsurgery of tubes | _____ | _____ | _____ |
| 077 | Skintumors | _____ | _____ | _____ |

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|-------|-------------------------------------|-------------------|----------------|------------------|
| 078 | Brachy therapy (radium) | _____ | _____ | _____ |
| 079 | Cystoscopy | _____ | _____ | _____ |
| 080 | Sacrospinous ligament | _____ | _____ | _____ |
| 081 | Sling procedure suspension | _____ | _____ | _____ |
| 081.1 | Laser vaporization of CO2 off warts | _____ | _____ | _____ |
| 081.2 | Ultrasound | _____ | _____ | _____ |
| 081.3 | Intra uterine manipulator | _____ | _____ | _____ |
| 081.4 | Endometrial Biopsy | _____ | _____ | _____ |

DECLARATION

I, the undersigned, attest that I will discharge at the Jersey City Medical Center only those Gynecological privileges which are specifically recommended by the Director of Obstetrics and Gynecology as indicated above.

Applicant's Signature

Director of Ob/Gyn

Date Approved by Board of Trustees

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**Jersey City Medical Center
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|------|---|-------------------|----------------|------------------|
| 024 | Destructive operations-fetus craniotomy, basiotripsy, decapitation, cranial puncture, cranioclasia, cleidotomy (Provide total # of cases performed in last 2 years) | _____ | _____ | _____ |
| 025 | Colpocentesis | _____ | _____ | _____ |
| 026 | Colpotomy | _____ | _____ | _____ |
| 027 | Amniotomy | _____ | _____ | _____ |
| 028 | Anesthesia - local | _____ | _____ | _____ |
| 029 | Anesthesia - pudendal block | _____ | _____ | _____ |
| 031 | Evacuation of vulver hematomata | _____ | _____ | _____ |
| 032 | Circumcision of infant | _____ | _____ | _____ |
| 033 | Repair of 3rd & 4th degree lacerations | _____ | _____ | _____ |
| 034 | Excision of vulvar lesion at delivery | _____ | _____ | _____ |
| 035 | Excision of vaginal cysts | _____ | _____ | _____ |
| 036 | Uterine packing | _____ | _____ | _____ |
| 037 | Curettage | _____ | _____ | _____ |
| 038 | Abortion Management | _____ | _____ | _____ |
| 039 | Post-partum tubal sterilization | _____ | _____ | _____ |
| 040 | Resuscitation of infant | _____ | _____ | _____ |
| 041 | Cervical biopsy during pregnancy also conization of cervix | _____ | _____ | _____ |
| 042 | Repair of incompetent internal cervical cerclage | _____ | _____ | _____ |
| 043 | Inversion of uterus | _____ | _____ | _____ |
| 044 | Hemorrhoid excision | _____ | _____ | _____ |
| 045 | Amniocentesis | _____ | _____ | _____ |
| 046 | Management of fetal death in utero | _____ | _____ | _____ |
| 050 | Internal version with extraction | _____ | _____ | _____ |
| 051 | Amnioscopy | _____ | _____ | _____ |
| 052 | Fetal blood scalp sampling | _____ | _____ | _____ |
| 053 | Intrauterine fetal transfusion (Provide total # of cases performed in last 2 years) | _____ | _____ | _____ |
| 054 | Antepartum testing | _____ | _____ | _____ |
| 055 | Antepartum testing-NST | _____ | _____ | _____ |

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|------|--|-------------------|----------------|------------------|
| 056 | Antepartum testing-OCT | _____ | _____ | _____ |
| 057 | Fetal surgery (Provide total # of cases performed in last 2 years) | _____ | _____ | _____ |
| 058 | Incompetent os surgery | _____ | _____ | _____ |
| 059 | Vacuum extractor | _____ | _____ | _____ |
| 060 | Ultrasound - 1st, 2nd, 3rd trimester | _____ | _____ | _____ |
| 061 | Percutaneous umbilical blood sampling (Provide total # of cases performed in last 2 years) | _____ | _____ | _____ |
| 062 | Intra uterus transfusion (Provide total # of cases performed in last 2 years) | _____ | _____ | _____ |
| 063 | CVS biophysical profile (Provide total # of cases performed in last 2 years) | _____ | _____ | _____ |
| 064 | Uterine vaginal packing | _____ | _____ | _____ |
| 065 | External version | _____ | _____ | _____ |

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Applicant's Signature

Director of Ob/Gyn

Date Approved by Board of Trustees