



Privilege/Operative Procedure	Check (√) if Requested	Chair Approval Initial if Yes Write Not Approved if No
Ovarian Cystectomy		
Salpingostomy		
Salpingoplasty		
Salpingectomy		
Myomectomy		
Laparoscopic Assisted Vaginal Hysterectomy (LAVH)		
Treatment of Ectopic Pregnancy		
Pre-Sacral Neurectomy		
Operative Hysteroscopy and/or Resectoscopy		
Lysis of Intrauterine Adhesions		
Metroplasty		
Myomectomy		
Tubal Catheterization		
Ablation of the Endometrium		
Sigmoidoscopy		
<b>Urogynecology</b>		
Cystoscopy, Urethroscopy		
Abdominal Sacral Colpopexy		
Sacrospinous Vaginal Suspension		
Complex Urodynamics		
Suburethral Sling		
Laparoscopic Burch Colposuspension		
Paravaginal Repair		
Fascia Lata Harvest		
Vaginal Suspension		
Vaginal mesh repairs		
Colpocleisis		
Vaginectomy		
Plastic Reconstruction of Vagina with or without Skin Grafts		
<b>Category III:</b> to be eligible for Category III privileges, applicants must have completed an ACGME approved OB/GYN residency program, be Board Certified or be a candidate for Board Certification, and have completed the appropriate fellowship. <b>Category III privileges are as follows:</b>		
<b>Gynecologic Oncology</b>		
Radical Vulvectomy with Inguino-Femoral Lymphadenectomy		
Pelvic Exenteration		
Radical Hysterectomy		
Ureteral Transplant of Ileal Loop, when related to Gynecologic Disease		
Colostomy, when related to Gynecologic Disease		
Colostomy Reversal		
Lymphadenectomy for Staging		
Lymph Node Dissection, Pelvic Para-Aortic		
Radical Vulvectomy with or without Lymph Node Dissection		

Name \_\_\_\_\_

Date \_\_\_\_\_

<b>Privilege/Operative Procedure</b>	<b>Check (√) if Requested</b>	<b>Chair Approval Initial if Yes Write Not Approved if No</b>
Operative Laparoscopy for Gynecologic Cancer		
Intestinal Resection and Re-Anastomosis <i>when related to Gynecologic Disease</i>		
<b>Maternal/Fetal Medicine</b>		
Invasive fetal procedures, i.e., intrauterine transfusions, fetal thoracocentesis, cardiac puncture, puncture of fetal bladder, placement of ventricular shunt valves and fetoscopy.		
Cordocentesis (PUBS)		
Chorionic Villus Sampling		
Amniocentesis (genetic)		
Intrauterine Laser <i>*complete laser portion in Category IV</i>		
External Cephalic Version		
<b>Reproductive Endocrinology</b>		
Tubal Reanastomosis/Reimplantation		
Oocyte Retrieval		
Embryo Transfer Procedures		
Gamete Intrafallopian Transfer		
Zygote Intrafallopian Transfer		
<b>Category IV: Special/Cross Disciplinary Procedures:</b>		
<b>Moderate (Conscious) Sedation - Criteria for Approval:</b> 1. Proof of Current BCLS certification (please attach); 2. Completion of age-appropriate basic airway management in-service by the UMMC Department of Anesthesia (and every two years thereafter for reappointment). <i>(Physicians board certified in Anesthesiology, Critical Care Medicine, Emergency Medicine, Neonatology, or Oral &amp; Maxillofacial Surgery are not required to fulfill criteria 2.)</i>		
<b>Laser Privileges (separate application required)</b>		
Carbon Dioxide		
Argon		
Nd-Yag		
Other: _____		
daVinci Surgical Robot Privileges (separate application required)		
<b>Ultrasound Procedures (please list)</b>		
Level I – Ultrasound examination of the fetus		
Level II – Ultrasound examination of the fetus		

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Division Chief, if applicable

\_\_\_\_\_  
Date

\_\_\_\_\_  
Hugh Mighty, MD, Chairman, Department of OB/GYN

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Confirming Signature  
*(required if any requested privilege is not approved)*

\_\_\_\_\_  
Date

Rev'd 12/09

**UNIVERSITY OF MARYLAND MEDICAL CENTER  
APPLICATION FOR INITIAL PRIVILEGES FOR CLINICAL USE OF LASERS**

NAME: \_\_\_\_\_

DEPT/DIVISION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

For which type of laser are you applying for privileges?

<b>Carbon Dioxide</b> _____ <b>Argon</b> _____ <b>Nd-YAG</b> _____ <b>Other</b> _____
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Approximately how many cases have you done with the laser?

<b>Carbon Dioxide</b> _____ <b>Argon</b> _____ <b>Nd-YAG</b> _____ <b>Other</b> _____
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For what types of surgery do you use the laser? \_\_\_\_\_

\_\_\_\_\_

**Formal courses taken in laser surgery:** Specify title of course, which types of lasers were used, institution where you took the course, date taken, number of hours of hands-on supervised use of the laser, CME credits earned. Enclose copy of CME certificate for the course.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Training with lasers during residency and/or during practice:** Where it occurred, who supervised you, number of cases done with supervision, dates.

\_\_\_\_\_

\_\_\_\_\_

After completing this form, please return it to Medical Staff Services, 110 South Paca Street, 8<sup>th</sup> Floor, Baltimore, MD 21201, or fax it to 410-328-6433.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department/Division Chief

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by Credentials Committee Member

\_\_\_\_\_  
Date

**UNIVERSITY OF MARYLAND MEDICAL CENTER  
APPLICATION FOR INITIAL PRIVILEGES FOR CLINICAL USE OF SURGICAL ROBOT**

NAME: \_\_\_\_\_

DEPT/DIVISION: \_\_\_\_\_

DATE: \_\_\_\_\_

For what types of surgery do you use the surgical robot? \_\_\_\_\_

\_\_\_\_\_

Approximately how many cases have you done with the surgical robot? \_\_\_\_\_

**Initial Appointment – Demonstration of competence with the daVinci robotic system  
(initial next to applicable criteria)**

\_\_\_\_\_ **Applicants without documentation of competence outside of University of Maryland Medical Center**

- Must be certified as having received comprehensive training in the form of an educational program provided by Intuitive Surgical that covers theory, instrumentation, complications, safety factors, and hands-on laboratory experience utilizing tissue and/or animal models. This is to include surgery on laboratory animals utilizing the daVinci robotic system.
- Under the Focused Practitioner Evaluation Policy, will be proctored for the first 5 (five) cases performed at UMMC by a practitioner in the same departmental specialty who has been certified to perform robotic surgery without mentoring. A proctor may be an approved proctor from Intuitive Surgical who is certified as a proctor by the Department Chair.
- Upon completion of five proctored cases
  - Following the completion of the last case performed under proctoring, it is the applicant's responsibility to forward, in consultation with the Chair of the Department, to the Credentials Committee their certificate of training. This certificate will include information that identifies the case, including procedure, outcome and any complications. The applicant is further responsible for forwarding to the Credentials Committee the recommendation from the proctor and the Chair of the Department that the applicant is competent to utilize the daVinci robotic system. If the proctor feels that initial competency has not been achieved after the first five procedures, an additional two or more procedures must be performed under proctoring until the proctor believes the applicant has achieved clinical competence.

\_\_\_\_\_ **Applicants with recent post graduate surgical training**

- Applicants who have received official training for robotic assisted surgery during residency and/or fellowship must have that training verified in writing by the appropriate departmental chairman and/or program director of the surgical training program. This written verification must attest to the current skills and competencies of the applicant. If the applicant received robotic training from Intuitive Surgical during their residency and/or fellowship, a certificate of completion will be obtained when applicable.
- A case log must be included that documents a minimum of 10 cases performed as the primary surgeon, any complications and outcomes of those cases.

\_\_\_\_\_ **Applicants privileged to perform robotic surgery at another facility**

- Applicants who are privileged at another JCAHO accredited facility to perform robotic surgery may request privileges by forwarding in writing to the Chair of their Department and to the Credentials Committee:
  - A letter from the Department Chair at the other facility attesting to their competency in performing robotic surgery.

NAME: \_\_\_\_\_

- A list of robotic surgery procedures performed at the other facility, including outcomes and complications. This list must include at least five cases.
- Recommendation to grant robotic surgical privileges is at the discretion of the Chair at UMMC, based upon his or her review of the above material and verbal discussion with the Chair of the Department or additional individuals at the other facility, as indicated.

**Formal courses taken in robotic laser surgery:** Specify title of course, institution where you took the course, date taken, number of hours of hands-on supervised use of the surgical robot, CME credits earned. **Enclose copy of CME certificate for the course.**

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**Training with surgical robot during residency and/or during practice:** Where it occurred, who supervised you, number of cases done with supervision, dates.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department/Division Chief

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by Credentials Committee Member

\_\_\_\_\_  
Date