

# PEDIATRIC UROLOGY PRIVILEGE FORM

**NAME:** \_\_\_\_\_ **EFFECTIVE DATE:** \_\_\_\_\_ **To** \_\_\_\_\_

**LEGEND:** 1 – Baptist                      2 –Beaches                      3 –Nassau                      4 – SV Southside                      5 – SV Riverside  
6 - Shands Jax/SJ                      7 - Wolfson                      8 - Brooks                      9 –South                      10 – SV Clay

The minimum education, training and experience qualifications for core privileges are as delineated in each hospital's Medical Staff Bylaws, Rules and Regulations, or policies. Please consult these documents to determine your eligibility to request these privileges.

To request Core Privileges, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	10	CORE PRIVILEGES	APPR
										Admit, assess, and treat either surgical or medical pediatric patients presenting with illnesses or injuries or malformation of the genitourinary system.	

To request Special Procedures, please place an "X" in the appropriate hospital column. If the condition/privilege you desire is not included on this form, please submit a separate written request along with appropriate documentation of training and/or experience.

1	2	3	4	5	6	7	8	9	10	SPECIAL PROCEDURES	APPR
										Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training or experience.	
										DaVinci Robot [Hospital 7++]	
										Deep Sedation [Hospital 7++]	
										Laparoscopic Urological Procedures [Hospital 7++]	
										Laser Surgery CO2 [ Hospital 7++]	
										Laser Surgery Holmium [ Hospital 7++]	
										Laser Surgery KTP [ Hospital 7++]	
										Laser Surgery Nd YAG [ Hospital 7++]	
										Lithotripsy - ESWL [Hospital 7++]	
										Moderate Sedation/Analgesia [Hospital 7++]	

**Acknowledgement of Practitioner:** I understand that (a) in exercising clinical privileges granted, I am constrained by each hospital's Medical Staff Policies, rules and regulations, and (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 applicable section of each hospital's Medical Staff Bylaws.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- If blacked out, this privilege is not available in this specialty at this hospital.
- ++ Please refer to this hospital's Bylaws or Rules and Regulations regarding specific criteria to be met before this privilege may be granted.