

# Regions Hospital

## Delineation of Privileges

### Urology

Applicant's Name: \_\_\_\_\_  
Last
First
M
Date

**Instructions:** Applicants must provide complete names and addresses for their references. Please DO NOT SEND letters of recommendation along with your application. These must be primary source verified by Regions Hospital. If documentation of cases or procedures is required, please attach case and/or procedural logs to your privilege delineation.

**CORE I- General Privileges Urology**

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
Privileges include admission, work-up, diagnosis, consult with, and treat either surgical or medical patients presenting with illnesses or injuries of the genitourinary system.	<ol style="list-style-type: none"> <li>1. MD or DO, MBBS</li> <li>2. Successful completion of an ACGME or AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency training program in Urology.</li> <li>3. Board certification in Urology or progressing toward certification.</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Documentation that the applicant has performed at least 50 general urological procedures during the past 24 months <u>and</u></li> <li>2. A letter of reference from the Residency Director or Chief of Urology from another hospital where the applicant has been affiliated for the last two years <u>or</u></li> <li>3. Names and addresses of two physician colleagues whom we may contact who can comment on the applicant's current clinical competence to perform the privileges requested.</li> </ol> <p>Please indicate names and addresses of the physicians whom we may contact.            Name: _____            Name of Facility: _____            Add: _____            Ph/Fax #: _____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> <li>1. If the applicant is not board certified in Urology, documentation of the provision of at least 50 urological procedures during the past 24 months is required <u>or</u></li> <li>2. If the applicant is board certified in Urology, evidence of continued board certification is required and.</li> <li>3. Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact.</li> </ol> <p>Name: _____            Name of Facility: _____            Add: _____            Ph/Fax: _____</p>

**CORE II- Special Privileges Urology**

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p><b>Lasers (Please specify)</b></p> <p><input type="checkbox"/> Holmium/greenlight/revolix</p> <p><input type="checkbox"/> Yag</p> <p><input type="checkbox"/> CO2</p> <p><input type="checkbox"/> Argon</p> <p><input type="checkbox"/> KTP</p> <p><input type="checkbox"/> Laparoscopic Urological procedures</p> <p><input type="checkbox"/> Visual Laser Ablation of the Prostate</p> <p><input type="checkbox"/> Robotic Surgery*</p> <p><input type="checkbox"/> Other – please specify</p> <p>_____</p> <p>_____</p>	<p>Same as Core I</p>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>Documentation of successful completion of an approved training program to perform in the of surgical laparoscopic lasers and</li> <li>Names and addresses of 2 physician colleagues whom we may contact who can comment on the applicant’s current clinical competence in the laser privileges requested.</li> <li>*Robotic Surgery – all urologists:               <ol style="list-style-type: none"> <li>Documentation of satisfactory completion of an approved FDA mandated training course (at least 8 hours including 3 hours of personal time on the system during training).</li> <li>Clinical privileges for open procedures that will be performed robotically.</li> <li>Documentation of having observed two robotic operations performed by an experience urologist.</li> <li>Documentation of having performed two proctored robotic operations.</li> </ol> </li> </ol> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> <li>Documentation demonstrating participation in at least 2 cases using robotic surgical system.</li> <li>Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact.</li> </ol> <p>Name: _____</p> <p>Name of Facility: _____</p> <p>Add: _____</p> <p>Ph/Fax: _____</p>

**TO BE COMPLETED BY APPLICANT:**

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges will not proceed until which time that the information is received.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY DIVISION/SECTION HEAD:**

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date