

**REAPPOINTMENT
DELINEATION OF PRIVILEGES
SPECIALTY OF UROLOGY**

I have reviewed the DOP/Roster provided to me by MSS and confirm as indicated below:

My DOP is accurate and reflects privileges relevant to my current practice

I have listed privileges that should be removed: _____

Printed Name: _____

Signature: _____

Date: _____

If your roster indicates that you hold any of the privileges listed below, you must provide the maintenance criteria as described, in order to maintain the privilege. Your maintenance criteria and attestation must be returned together.

CURO-1(e) - DA VINCI SURGICAL ROBOT

Criteria for Maintenance of Privileges:

The Physician must submit a documentation of a minimum of three (3) cases over the past two (2) years based on acceptable results of ongoing professional practice evaluation and outcomes to reapply for da Vinci Surgical Robot. This will be reviewed at the time of reappointment. Physicians who would like to continue to hold any special privileges but are unable to document the minimal number will be requested to voluntarily withdraw their request for such privileges and to complete the necessary proctoring forms.

STOP:

UNLESS YOU ARE REQUESTING NEW OR ADDITIONAL PRIVILEGES, YOU DO NOT NEED TO GO BEYOND THIS POINT.

ATRIUM HEALTH
DELINEATION OF PRIVILEGES
SPECIALTY OF UROLOGY

Print Name _____

	YES		NO*	I have participated in direct patient care in the hospital setting within the past two (2) years.
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*If the answer is "No", please do not complete this form. Contact the Medical Staff Office at (704) 355-2147 for additional instructions regarding the required proctoring process.

- Initial appointment** **Reappointment** **Updated DOP** **Request for Clinical Privileges**

To be eligible for core privileges in Urology, the applicant must meet the following qualifications:

- If the applicant is not currently certified by the American Board of Urology (ABMS) or the American Osteopathic Association (AOA), the applicant must:
 1. Provide documentation of successful completion, within the past five (5) years, of an ACGME or AOA accredited residency training program in Urology; **AND**
 2. Documentation of the performance of at least fifty (50) surgical procedures during the past two (2) years.
- If the applicant is currently certified by the American Board of Urology (ABMS) or the American Osteopathic Association, (AOA), the applicant must:
 1. Documentation of the performance of at least fifty (50) surgical procedures during the past two (2) years.
- Carolinas HealthCare System Kings Mountain applicants may be eligible for Core Urology privileges by meeting the following qualifications:
 1. Documentation of the performance of at least fifty (50) urological surgical procedures during the past two (2) years.

Print Name _____

NOTE 1: Physicians must apply for “CORE” privileges in order to be eligible for clinical privileges in the specialty of Urology at any facility within Atrium Health.

NOTE 2: “CORE” privileges cannot be amended or altered in any way.

NOTE 3: Please note that the exercise of certain privileges enumerated herein is necessarily limited by the operational, and resource constraints of the facility. All procedures must be performed within a clinical setting with the capabilities and organizational structure required to provide appropriate support.

Please check appropriate blocks when applying for privileges:

CMC	Pineville	University	CR	Lincoln	NorthEast	Union	Stanly	Anson	Cleveland	Kings Mountain		UROLOGY CORE PRIVILEGES
			N/A								CURO-1	Privileges to evaluate, diagnose, consult, provide non-surgical care and provide preoperative, intraoperative and postoperative surgical care to patients of all ages except as specifically excluded from practice and except for those special procedures listed below to correct or treat illnesses, disorders, diseases or injuries of the genitourinary system.

NOTE: Urology Core Privileges include but are not limited to all forms of prostatectomy, including biopsy; Anterior pelvic exenteration; Appendectomy as component of urologic procedure; Bladder instillation of anticarcinogenic agent; Bowel resection as component of urologic procedure; Circumcision; Continent reservoirs; Creation of neobladders; Cystolithotomy; Cystoscopy; Endoscopic destruction of urethral valves, child; Enterostomy as component of urologic procedure; Excision of retroperitoneal cyst or tumor; Excision of urethral valves; Exploration of retroperitoneum; Female sphincter prosthesis; Ileal or intestinal conduit; Inguinal herniorrhaphy as related to urologic operation; Insertion of totally indwelling ureteral stent; Laparotomy for diagnostic or exploratory purposes urologic related conditions; Lymph node dissection-inguinal, retroperitoneal, or iliac; Male sphincter prosthesis; Management of congenital anomalies of the genitourinary tract, including epispadias and hypospadias; Microscopic surgery-epididymovasostomy, vasotomy; Open renal stone surgery (e.g. pyelolithotomy); Open renal biopsy; Operation for Peronie’s disease, including grafting; Operation for ureterocele; Operation for urethral fistula; Other plastic and reconstructive procedures on external male genitalia; Pelvic and inguinal lymph node biopsy; Percutaneous nephrolithotripsy; Periurethral collagen injections; Plastic and reconstructive procedures on ureter, bladder, and urethra; Reconstructive procedures on external male genitalia requiring prosthetic implants or foreign materials; Renal endoscopy through established nephrostomy or pyelostomy; Surgery of the testicle, scrotum, epididymis, and vas deferens, including biopsy, excision and reduction of testicular torsion, and orchiopexy; Surgery upon the adrenal gland; Surgery upon the kidney, including total or partial nephrectomy, for malignant or benign disease, including radical transthoracic nephrectomy; Surgery upon the penis; Surgery upon the ureter and renal pelvis; Surgery upon the urinary bladder for benign or malignant disease, including partial resection and removal of stones and foreign bodies; Testicular biopsy; Total or simple cystectomy; Transurethral surgery, including resection of prostate and bladder tumors; Transvesical ureterolithotomy; Ureteral substitution; Uretero-calyceal anastomosis; Ureteroscopy; Urethral suspension procedures; Urethroscopy; Ventral/flank herniorrhaphy as related to urologic operation; Visual urethrotomy; lithotripsy; implantation of interstim continence control therapy; repair of evisceration for urologic surgery; use of adjunct energy sources such as lasers and cryosurgery; diagnostic and therapeutic laparoscopy.

Subspecialty certification by the American Board of Urology signifies that the physician is so certified, has done special training, and has successfully met all the requirements of the subspecialty certification. A urologist certified by the American Board of Urology who holds a general urology certificate is trained, qualified, and certified to perform urologic procedures on pediatric and female pelvic medicine and reconstructive surgery patients.

Print Name _____

*** Special privileges (see qualifications and/or specific criteria) - PROVIDE THE NUMBER OF PROCEDURES PERFORMED WITHIN THE PAST TWO YEARS AND FACILITY WHERE THE PROCEDURES WERE PERFORMED.**

CMC	Pine.	Univ.	CR	Lin.	NE	Union	Stanly	Anson	Cle.	KM		UROLOGY SPECIAL PRIVILEGES	Minimum Number Required	Number Performed Within The Past 2 Years	Location
	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	CURO-1(a)*	Prostate Brachytherapy (Radioactive Seed Implants to treat prostate cancer)	See criteria		
	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	CURO-1(b)*	Rectal Probe Electroejaculation	See criteria		
			N/A		N/A	N/A	N/A	N/A		N/A	CURO-1(c)*	Prostate Cryoablation	5		
			N/A		N/A	N/A	N/A	N/A		N/A	CURO-1(d)*	Laparoscopic Renal Cryoablation	See criteria		
CMC	Pine.	Univ.	CR	Lin.	NE	Union	Stanly	Anson	Cle.	KM		DA VINCI SURGICAL ROBOT	Minimum Number Required	Number Performed Within The Past 2 Years	Location
			N/A				N/A	N/A		N/A	CURO-1(e)*	da Vinci Surgical Robot	See criteria		
CMC	Pine.	Univ.	CR	Lin.	NE	Union	Stanly	Anson	Cle.	KM		PEDIATRIC UROLOGY SPECIAL PRIVILEGES	Minimum Number Required	Number Performed Within The Past 2 Years	Location
			N/A		N/A	N/A	N/A	N/A		N/A	CURO-1(f)*	Pediatric Inguinal Herniorrhaphy	10		

Print Name _____

CMC	Pineville	University	CR	Lincoln	NorthEast	Union	Stanly	Anson	Cleveland	Kings Mountain		CORE UROLOGY PRIVILEGES – REHABILITATION HOSPITAL SETTING <u>ONLY</u>
N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	CURO-2	Privileges include evaluation and management, as well as procedures approved for performance within the acute rehabilitation setting, in conjunction with the comprehensive rehabilitation treatment plan.

PRIVILEGES REQUESTED BY:

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Atrium Health and;

I understand that:

- (a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
- (b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

I attest that I am not currently a user of illegal drugs or do not currently abuse the use of legal drugs.

I attest that I do not have a physical or mental condition which could affect my motor skills or ability to exercise the clinical privileges requested or that I require an accommodation in order to exercise the privileges requested safely and competently.

Signature

Date

Print Name

CURO-1(a) PROSTATE BRACHYTHERAPY (RADIOACTIVE SEED IMPLANTS TO TREAT PROSTATE CANCER)

EXPLANATION: Prostate Brachytherapy (Radioactive Seed Implants to treat prostate cancer) shall be performed by physicians who have been granted the privileges to do so and will be done in concert with a Radiation Oncologist. The procedure will be performed using trans-rectal ultrasound guidance.

QUALIFICATIONS: The applicant shall have the burden of producing adequate information for proper evaluation of his competence and qualifications and for resolving any doubts about such qualifications. This documentation may be provided by the applicant, and/or by a letter from the proctor stipulating that the procedures have been performed by the applicant under the direct supervision of the proctor.

The applicant must meet the following:

1. Provide documentation of the successful completion of a residency program in Urology within the past two (2) years and have written documentation from the Program Director demonstrating competency in Prostate Brachytherapy; **OR**
 1. Proof of attendance at an Accredited Course in Ultrasound Guided Brachytherapy which includes didactic and workshop training; **AND**
 2. Submit the PERMISSION TO BE PROCTORED REQUEST FORM requesting concurrent proctoring by a urologic physician or radiation oncologist who currently holds privileges to perform Prostate Brachytherapy. You must provide documentation of proctoring for two (2) procedures.
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CURO-1(b) RECTAL PROBE ELECTROEJACULATION

EXPLANATION: Electroejaculation is a procedure to harvest sperm from men who have ejaculatory dysfunction.

QUALIFICATIONS: Urology residency training or post doctorate fellowship training or (there are post graduate training courses).

The applicant must meet the following:

1. Provide documentation of the successful completion of a residency program in Urology within the past two (2) years and have written documentation from the Program Director demonstrating competency in Rectal Probe Electroejaculation; **OR**
 1. Proof of attendance of additional course work and continuing medical education credits which demonstrated competence in the procedure; **AND**
 2. Submit the PERMISSION TO BE PROCTORED REQUEST FORM requesting concurrent proctoring by a physician who currently holds privileges to perform Rectal Probe Electroejaculation. You must provide documentation of proctoring for two (2) procedures.
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CURO-1(c) PROSTATE CRYOABLATION

EXPLANATION: Cryoablation is the ablation of tissue by local induction of extremely cold temperatures which is a minimally invasive treatment option offering low morbidity, minimal blood loss, short hospital stay and high rates of negative post-treatment biopsies. Cryoablation enables more efficient freezing of the prostate gland while reducing damage to surrounding tissues, notably, the rectum, urethra, and external urinary sphincter. Cryoablation is recognized as a therapeutic option for prostate cancer.

The applicant must meet the following:

1. Provide documentation of the successful completion of a residency program in Urology within the past two (2) years and have written documentation from the Program Director demonstrating competency in Prostate Cryoablation; **OR**
 1. Proof of attendance at an Accredited Course in Cryotherapy which includes didactic and workshop training; **AND**
 2. Provide documentation from the current director/chief attesting to sufficient experience and competence and provide documentation that demonstrates proficiency as evidenced by quality data, i.e., case log to include outcomes, on five (5) cases within the past two (2) years; **OR**
 2. Submit the PERMISSION TO BE PROCTORED REQUEST FORM requesting concurrent proctoring by a physician who currently holds privileges to perform Prostate Cryoablation. You must provide documentation of proctoring for two (2) procedures.
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CURO-1(d) LAPAROSCOPIC RENAL CRYOABLATION

EXPLANATION: Laparoscopic renal cryoablation is an excellent option for the management of selected renal tumors. The technique is usually not technically demanding and the procedure offers the Urologist an excellent introduction to the laparoscopic treatment of renal diseases. The procedure is facilitated by thoughtful planning including; appropriate patient selection, choice of surgical approach (transperitoneal versus retroperitoneal), and careful consideration of the surgical team and equipment available.

The applicant must meet the following:

1. Provide documentation of the successful completion of a residency program in Urology within the past two (2) years and have written documentation from the Program Director demonstrating competency in Laparoscopic Renal Cryoablation; **OR**
1. Proof of attendance at an Accredited Course in Laparoscopic Renal Cryotherapy which includes didactic and workshop training; **AND**
2. Submit the PERMISSION TO BE PROCTORED REQUEST FORM requesting concurrent proctoring by a physician who currently holds privileges to perform Laparoscopic Renal Cryoablation. You must provide documentation of proctoring for two (2) procedures.

CURO-1(e) DA VINCI SURGICAL ROBOT

EXPLANATION: The da Vinci Surgical System itself is a large console, controlled by the surgeon, with three interactive robotic arms, specialized surgical instrumentation, and a high-performance video system. The video system provides surgeons with a highly magnified, three-dimensional view of a patient's interior, while the surgical instrumentation allows for improved precision and manipulation in tight spaces.

The applicant must meet the following:

1. Apply for and be granted privileges for Diagnostic and Laparoscopy privileges; **AND**
2. Current privileges to perform the procedure open; **AND**
3. Provide documentation of the successful completion of a residency or fellowship program in Urology within the past two (2) years and have written documentation from the Program Director demonstrating competency in da Vinci to include the proficient performance of three (3) cases; **AND**
4. Documentation of proficiently performing three (3) da Vinci cases within the past two (2) years.

OR

1. Apply for and be granted privileges for Diagnostic and Laparoscopy privileges; **AND**
2. Current privileges to perform the procedure open; **AND**
3. Documentation of successful completion of a formal course on the da Vinci system offered through Intuitive Surgical; **AND**
4. Verification by the approved Robotics Proctoring Physician that the Applicant was successfully proctored for a minimum of three (3) robotic-assisted patient cases within the past two (2) years; **OR**
4. Documentation of proficiently performing three (3) da Vinci cases within the past two (2) years.

Criteria for Maintenance of Privileges:

The Physician must submit a documentation of a minimum of three (3) cases over the past two (2) years based on acceptable results of ongoing professional practice evaluation and outcomes to reapply for da Vinci Surgical Robot. This will be reviewed at the time of reappointment. Physicians who would like to continue to hold any special privileges but are unable to document the minimal number will be requested to voluntarily withdraw their request for such privileges and to complete the necessary proctoring forms.

CURO-1(g) PEDIATRIC INGUINAL HERNIORRHAPHY

EXPLANATION: An inguinal hernia is a condition in which intra-abdominal fat or part of the small intestine, also called the small bowel, bulges through a weak area in the lower abdominal muscles. An inguinal hernia occurs in the groin—the area between the abdomen and thigh. This type of hernia is called inguinal because fat or part of the intestine slides through a weak area at the inguinal ring, the opening to the inguinal canal. An inguinal hernia appears as a bulge on one or both sides of the groin. An inguinal hernia can occur any time from infancy to adulthood and is much more common in males than females and tend to become larger with time.

The applicant must meet the following:

1. Provide documentation of the successful completion of a residency or fellowship program in Urology within the past two (2) years and have written documentation from the Program Director demonstrating competency in Pediatric Inguinal Herniorrhaphy; **OR**
1. Provide a minimum number of ten (10) cases performed within the past two (2) years; **OR**
1. Submit the PERMISSION TO BE PROCTORED REQUEST FORM requesting concurrent proctoring by a physician who currently holds privileges to perform Pediatric Inguinal Herniorrhaphy. You must provide documentation of proctoring for ten (10) procedures.

CASE LOG

Physician's Name: _____

Date: _____

	DATE	MEDICAL RECORD NUMBER	PROCEDURE TYPE	Name of procedure (as listed on DOP, e.g. CRAD-1(a))
1				
2				
3				
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30				
			TOTAL	