Union West Surgery Center
PRIVILEGE REQUEST: Ob/Gyn

Provider Printed Name: _____

Provider Signature: _____

Date: _____

PROCEDURE	REQUESTED	APPROVED
ANESTHESIA LOCAL		
ANESTHESIA REGIONAL		
ANESTHESIA TOPICAL		
BIOPSY OF VULVAR LESIONS		
CAUTERIZATION OF VENEREAL WARTS		
CERCIEGE		
CERVICAL CONIZATION/COLPOSCOPY		
COLPOSCOPY/COLPORRHAPHY		
COLPOTOMY		
CONE/VAGINAL BIOPSY		
CRYO CAUTERIZATION OF CERVIX/VAGINA		
DILATION AND CURETTAGE (D&C)		
DILATION AND EVACUATION (D&E)		
ENDOMETRIAL ABLATION		
EXAMINATION UNDER ANESTHESIA		
EXCISION EXTERNAL LESION		
EXCISION/MARSUPIALIZATION BARTHOLIN CYST		
HISTORY AND PHYSICAL		
HYMENOTOMY		
HYSTEROSCOPY/PELVISCOPY (POLYPECTOMY, MYOMECTOMY)		
INCISION AND DRAINAGE (I&D) OF VULVAR CYST		
INTERPRETATION OF X-RAYS		
LAPAROSCOPIC OOPHORECTOMY/SALPINGECTOMY		
LAPAROSCOPY,DIAGNOSCIE/OPEN		
LASER OF VULVAR LESIONS/WARTS		
MINI LAPAROTOMY		
MISSED/INCOMPLETE ABORTION		
OPEN LAPAROTOMY		
SIMPLE VULVECTOMY		
SUPERVISION OF NON-PHYSICIAN PERSONNAL		
TRANSCERVICAL BALLOON TUBOPLASTY (TBT)		
TUBAL LIGATION VAGINAL/LAPAROSCOPIC		

Medical Executive Committee - Approved By:	Approval Date:
Board of Managers — Approved By:	Approval Date: