

900 N. MICHIGAN SURGERY CENTER

**PRIVILEGE REQUEST FORM
GASTROENTEROLOGY**

I am applying for the following privileges of which I am also currently credentialed at _____,
an Illinois hospital.

REQUESTED	GRANTED	PROCEDURE
_____	_____	Special Studies, Invasive
_____	_____	Other respiratory tract intubation
_____	_____	Esophageal tamponade (Blakemore/Sengstaken)
_____	_____	Insertion naso-gastric tube
_____	_____	Bronchial lavage
_____	_____	Inject chemotherapy agent
_____	_____	Biopsy Procedure, Endoscopic
_____	_____	Bronchus (brushing)
_____	_____	Lymph node
_____	_____	Bone marrow
_____	_____	Small intestine
_____	_____	Rectum
_____	_____	Pancreas
_____	_____	Skin
_____	_____	Biopsy Procedure, Excisional
_____	_____	Thyroid (open)
_____	_____	Lung
_____	_____	Pleura
_____	_____	Pericardium
_____	_____	Lymph node
_____	_____	Bone marrow
_____	_____	Small Intestine
_____	_____	Rectum
_____	_____	Liver
_____	_____	Pancreas
_____	_____	Abdominal wall

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REQUESTED	GRANTED	PROCEDURE
_____	_____	Peritoneum
_____	_____	Kidney
_____	_____	Soft tissue
_____	_____	Skin
_____	_____	Biopsy Procedure, Percutaneous
_____	_____	Thyroid
_____	_____	Lung
_____	_____	Mediastinum (closed)
_____	_____	Pericardium
_____	_____	Lymph node
_____	_____	Bone marrow
_____	_____	Spleen
_____	_____	Rectum
_____	_____	Liver
_____	_____	Pancreas
_____	_____	Abdominal wall
_____	_____	Kidney
_____	_____	Soft tissue
_____	_____	Skin
_____	_____	Endoscopy Procedures
_____	_____	Laryngoscopy
_____	_____	Bronchoscopy flexible
_____	_____	Bronchoscopy with biopsy
_____	_____	Mediastinoscopy with biopsy
_____	_____	Esophagoscopy with biopsy
_____	_____	Gastroscopy with biopsy
_____	_____	Duodenoscopy with biopsy
_____	_____	Sigmoidoscopy flexible
_____	_____	Colonoscopy with biopsy
_____	_____	Polypectomy of large intestine

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REQUESTED	GRANTED	PROCEDURE
_____	_____	Rigid Procto/sigmoidoscopy
_____	_____	Proctosigmoidoscopy with biopsy
_____	_____	E.R.C.P.
_____	_____	Peritoneoscopy with biopsy
_____	_____	Special Study, Non-invasive
_____	_____	Esophageal dilation
_____	_____	Other (Please Specify):
_____	_____	_____
_____	_____	_____
_____	_____	_____

Practitioner's Signature _____ Print Name _____ Date _____

Medical Director Approval, 900 N. Michigan Surgical Center _____ Date _____

Governing Body Approval _____ Date _____