

**LEHIGH VALLEY HEALTH NETWORK**  
**CLINICAL PRIVILEGES IN GENERAL SURGERY**

Initial  Renewed   
 Effective from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_

**R = Requested G = Recommended As Requested C = Recommended with Conditions N = Not Recommended**

**R G C N POPULATION**

- |                          |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pediatric: Birth - 25 Years (LVHN Surgery Center-Tilghman - 6 months - 1 Year and LVHN Children's Surgery Center - 6 months - 1 Year) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adults: 13 - 65 Years   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Geriatrics: Over 65 Years   |

**R G C N NO CLINICAL PRIVILEGES**

- |                          |                          |                          |                          |                        |
|--------------------------|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | No Clinical Privileges |
|--------------------------|--------------------------|--------------------------|--------------------------|------------------------|

**R G C N GENERAL PRIVILEGES**

- |                          |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Admitting (includes inpatient, outpatient procedures, and observation) (1,2,3,5,6,7,8,10,11,13) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consulting Privileges (1,2,3,5,6,7,8,10,11,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History and Physical (1,2,3,5,6,7,8,10,11,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prescribing Privileges (1,2,3,5,6,7,8,10,11,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | First Assistant at Surgery Only (1,2,3,5,6,7,8,10,11,13)  |

**R G C N SOFT TISSUE**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Above Knee Amputation (1,2,5,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Below Knee Amputation (1,2,5,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision of benign and malignant soft tissue tumors (1,2,3,7,8,10,13)                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision of retroperitoneal tumors (1,2,,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture (1,2,4,5,6,7,8,10,13) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle biopsy (1,2,3,5,6,7,8,10,13)  |

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**R G C N SOFT TISSUE**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radial debridement necrotizing soft tissue infection (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (1,2,3,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Split/full thickness autograft, trunk, arms, legs (1,2,3,5,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sural nerve biopsy (1,2,3,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temporal artery biopsy (1,2,3,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Treatment of superficial wound dehiscence, simple closure (1,2,3,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wound debridement (1,2,3,5,6,7,8,9,10,13)

**R G C N HERNIA**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; repair initial inguinal hernia (TEP) (TAPP) (1,2,3,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; repair, incisional hernia (1,2,3,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; repair, ventral, umbilical, spigelian or epigastric hernia (1,2,3,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orchiectomy associated with hernia repair (1,2,3,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair epigastric hernia (1,2,3,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair initial femoral hernia (1,2,3,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair initial incisional or ventral hernia (1,2,3,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair initial inguinal hernia, age 5 years or older (1,2,3,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair recurrent inguinal hernia (1,2,3,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair spigelian hernia (1,2,3,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair umbilical hernia, age 5 years or older (1,2,3,7,8,9,10,13)

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**R G C N APPENDIX**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Appendectomy (1,2,3,7,8,10,13)                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Incision and drainage of appendiceal abscess (1,2,3,7,10,13) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, surgical, appendectomy (1,2,3,7,8,10,13)        |

**R G C N BREAST**

- |                          |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biopsy of breast, open, incisional (1,2,3,7,8,9,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biopsy of breast, percutaneous, needle core (1,2,3,7,8,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision of breast lesion identified by preoperative placement of radiological marker (1,2,3,7,8,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision of cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (1,2,3,7,8,9,10,13)    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Modified radical mastectomy (1,2,3,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Partial mastectomy (1,2,3,7,8,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Placement of mammosite catheter for accelerated partial breast irradiation* (1,2,3,10,13) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Port Placement (1,2,3,7,8,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Puncture aspiration of cyst of breast (1,2,3,7,8,9,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sentinel node mapping and biopsy/dissection* (1,2,3,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved)                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stereotactic core needle biopsy of breast* (1,2,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved)                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Total mastectomy (1,2,3,7,8,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ultrasound guided core needle biopsy (1,2,3,7,8,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ultrasound guided percutaneous breast interventional procedures* (1,2,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved)          |

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**R G C N ESOPHAGUS**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulectomy of hypopharynx or esophagus with or without myotomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Esophagogastric fundoplasty (e.g., Nissen, Belsey IV, Hill procedure) (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Esophagogastric fundoplasty, with fundic patch (Thal-Nissen procedure) (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Esophagomyotomy (Heller type) abdominal approach (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula or for previous esophageal exclusion; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es) (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula or for previous esophageal exclusion; with stomach, with or without pyloroplasty (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical, esophagogastric fundoplasty (e.g., Nissen, Toupet procedures) (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed, with implantation of mesh (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed, without implantation of mesh (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Partial esophagectomy, 2/3 with thoractomy and separate abdominal incision, with or without proximal gastectomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Partial esophagectomy or abdominal approach (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Partial thoracoabdominal or abdominal approach (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total or near total esophagectomy with thoractomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total or near total esophagectomy without thoractomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total or partial esophagectomy without reconstruction (1,2,7,10,13)

**R G C N STOMACH**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision, local; malignant tumor of stomach (1,2,7,10,13)
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**R   G   C   N   STOMACH**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision, local; ulcer or benign tumor of stomach (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrectomy, partial, distal; with gastrojejunostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrectomy, partial, distal; with gastroduodenostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrectomy, partial, distal; with Roux-en-Y reconstruction (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrectomy, total; with esophagoenterostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrectomy, total; with formation of intestinal pouch, any type (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrectomy, total; with Roux-en-Y reconstruction (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrojejunostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrorrhaphy, suture or perforated duodenal or gastric ulcer, wound or injury (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrostomy, open (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrotomy; with exploration or foreign body removal (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopic gastrostomy (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopic partial/total gastrectomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopic pyloroplasty (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopic truncal/highly selective vagotomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pyloromyotomy, pyloroplasty (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vagotomy including pyloroplasty, with or without gastroenterostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vagotomy when performed with partial distal gastrectomy (1,2,7,10,13)

**R   G   C   N   SMALL BOWEL**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Closure of enteroenteric or enterocolic fistula (1,2,7,10,13)
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**R   G   C   N   SMALL BOWEL**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Closure of enterotomy, large or small intestine (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Closure of enterovesical fistula; without intestinal or bladder resection (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Closure of intestinal cutaneous fistula (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Continent ileostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enterolysis (1,2,7,8,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision of lesion of mesentery (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision of Meckel's diverticulum (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ileostomy or jejunostomy, non-tube (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal stricturoplasty with or without dilation, for intestinal obstruction (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical, enterolysis (1,2,5,7,8,10)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; enterectomy, resection of small intestine, resection and anastomosis (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; jejunostomy (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Placement of tube jejunostomy (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduction of volvulus, intussusception, internal hernia by laparotomy (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suture of small intestine for perforated ulcer, diverticulum, wound, injury or rupture, perforation (1,2,5,7,10,13)

**R   G   C   N   COLON**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colectomy, partial; with coloproctostomy (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colectomy, partial; with end colostomy and closure of distal segment (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colectomy, partial; with removal of terminal ileum with ileocolostomy (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula (1,2,5,7,10,13)

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**R G C N COLON**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colectomy, total, abdominal, with proctectomy, with ileostomy (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy and rectal mucosectomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colectomy, total, abdominal, without proctectomy; with continent ileostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; colectomy, partial with anastomosis (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy, with colostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; colostomy or skin level cecostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Placement, enterostomy or cecostomy, tube open (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repair of large intestine for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy (1,2,5,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Revision of colostomy; with repair of paracolostomy hernia (1,2,7,10,13)

**R G C N ANORECTAL**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anorectal examination under anesthesia (1,2,3,5,6,7,8,9,10,13)
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# LEHIGH VALLEY HEALTH NETWORK

## CLINICAL PRIVILEGES IN GENERAL SURGERY

Initial       Renewed   
 Effective from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_

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**R   G   C   N   ANORECTAL**

R	G	C	N	ANORECTAL
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Closure of rectovesical fistula (1,2,3,7,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Destruction of rectal tumor, transanal approach (1,2,3,7,8,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach (1,2,3,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision of rectal tumor; transanal approach, not including muscularis propria (TEM)* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoidectomy, internal and external (1,2,3,7,8,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incision and drainage of deep supralevator, pelvirectal or retrorectal abscess (1,2,3,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incision and drainage of intramural, intramuscular or submucosal abscess, transanal, under anesthesia (1,2,3,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incision and drainage of ischiorectal and/or perirectal abscess (1,2,3,,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular with or without placement of seton (1,2,3,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incision and drainage of submucosal abscess, rectum (1,2,3,,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incision of thrombosed hemorrhoid, external (1,2,3,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; proctectomy, complete combined abdominoperineal, with colostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical; proctopexy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic exenteration for colorectal malignancy, with proctectomy with removal of bladder and ureteral transplantations, and/or hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s) (1,2,7,10)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pilonidal cystectomy (1,2,3,5,6,7,8,9,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proctectomy, combined abdominoperineal pull-through procedure with creation of colonic reservoir with diverting enterostomy when performed (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proctectomy, combined abdominoperineal, pull-through procedure (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proctectomy; complete, combined abdominoperineal, with colostomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proctectomy; partial resection of rectum, transabdominal approach (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proctectomy; partial with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir with or without loop ileostomy (1,2,7,10,13)



**LEHIGH VALLEY HEALTH NETWORK**  
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**R G C N ANORECTAL**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Proctosigmoidoscopy, rigid; diagnostic (1,2,7,8,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rectal ultrasound* (1,2,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sigmoidoscopy, flexible; diagnostic (1,2,5,6,7,8,9,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Surgical treatment of anal fistula, subcutaneous (1,2,3,5,6,7,8,9,10,13)                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Transrectal drainage of pelvic abscess (1,2,5,7,8,10,13)   |

**R G C N LIVER**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biopsy of liver, wedge (1,2,3,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatectomy, resection of liver, partial lobectomy (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopic liver resection (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, surgical, ablation of liver tumors; radiofrequency* (1,2,7,10,13) (*Must satisfy criteria for Radiofrequency Ablation of Neoplasms) |

**R G C N BILIARY TRACT**

- |                          |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biliary endoscopy, intraoperative (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cholecystectomy (1,2,3,5,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cholecystectomy with exploration of common bile duct (1,2,3,5,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cholecystoenterostomy (1,2,3,5,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Choledochoenterostomy (1,2,3,5,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Choledochotomy or choledochostomy with exploration, drainage, or removal of calculus, with or without cholecystostomy, without transduodenal sphincterotomy or sphincteroplasty (1,2,5,7,10,13) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision of bile duct tumor with or without primary repair of bile duct, extrahepatic (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision of choledochal cyst (1,2,7,10,13)  |

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**R G C N BILIARY TRACT**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, common bile duct exploration* (1,2,3,5,7,10,13) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, surgical; cholecystectomy* (1,2,3,5,7,10,13) (*Must satisfy certain credentialing criteria to be approved)    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, surgical; cholecystoenterostomy (1,2,5,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Transduodenal sphincterotomy or sphincteroplasty with or without transduodenal extraction of calculus (1,2,5,7,10,13)      |

**R G C N PANCREAS**

- |                          |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision of ampulla of Vater (1,2,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision of lesion of pancreas (1,2,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Exploratory laparotomy, exploratory celiotomy with or without biopsy (1,2,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Internal anastomosis of pancreatic cyst to gastrointestinal tract, direct (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopic excision of pancreatic mass(es) (1,2,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopic partial/total pancreatectomy (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pancreatectomy, distal subtotal, with or without splenectomy; with pancreaticojejunostomy (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy with pancreaticojejunostomy (1,2,7,10,13) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pancreatectomy, total (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pancreaticojejunostomy, side-to-side anastomosis (1,2,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis (1,2,7,10,13)   |

**R G C N NECK/THYROID/PARATHYROID/ADRENAL**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adrenalectomy, partial or complete (1,2,7,10,13)           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Biopsy thyroid, percutaneous core needle (1,2,3,7,8,10,13) |

**LEHIGH VALLEY HEALTH NETWORK**  
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**R   G   C   N   NECK/THYROID/PARATHYROID/ADRENAL**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision brachial cleft cyst (1,2,3,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision cystic hygroma (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision of thyroglossal duct cyst or sinus (1,2,3,7,8,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incision and drainage of thyroglossal duct cyst, infected (1,2,3,7,8,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy, surgical with adrenalectomy, partial or complete (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Modified neck dissection - unilateral/bilateral (1,2,3,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroidectomy or exploration of parathyroid (MIRP) (1,2,3,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radical neck dissection - unilateral/bilateral (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sialoadenectomy, partial/complete (1,2,7,8,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thymectomy (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroidectomy, total or complete (1,2,3,4,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy (1,2,3,7,10,13)

**R   G   C   N   SPLEEN/LYMPHATICS**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Axillary lymphadectomy (1,2,3,7,8,9,10,12)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Biopsy or excision of lymph node(s) (1,2,3,4,7,8,10,12)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cervical lymphadenectomy, complete (1,2,3,7,10)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cervical lymphadenectomy, modified radical neck dissection (1,2,3,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision of cystic hygroma, axillary or cervical (1,2,3,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inguinal lymphadenectomy (1,2,3,7,8,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injection procedure for identification of sentinel node (1,2,7,8,10,13)

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**R G C N SPLEEN/LYMPHATICS**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, surgical splenectomy (1,2,5,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, surgical with retroperitoneal lymph node biopsy/lymphadenectomy (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes (1,2,7,10,13)                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Repair of ruptured spleen (1,2,5,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic and renal nodes (1,2,7,10,13)                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sentinel lymph node mapping and biopsy/dissection* (1,2,3,4,7,10,13) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Splenectomy (1,2,5,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Suture and/or ligation of thoracic duct (1,2,5,7,10,13)  |

**R G C N DIAPHRAGM**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopic repair of diaphragmatic hernia (1,2,5,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | LINX Reflux Management System* (1,2,3) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Repair, diaphragmatic hernia (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Repair, laceration of diaphragm (1,2,5,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Repair, paraesophageal hiatal hernia (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Resection, diaphragm with simple repair (1,2,7,10,13)  |

**R G C N ABDOMEN/GENERAL**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diagnostic laparoscopy with or without biopsy (1,2,3,,5,7,8,9,10,13)                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Exploratory laparotomy, exploratory celiotomy with or without biopsy (1,2,5,7,8,10,13)               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insertion of intraperitoneal cannula or catheter for drainage or dialysis, temporary (1,2,5,7,10,13) |

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**R G C N ABDOMEN/GENERAL**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insertion of intraperitoneal cannula or catheter with subcutaneous reservoir, permanent (1,2,5,7,10,13)                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Omental flap, extra-abdominal (1,2,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Single incision laparoscopic surgery (SILS)* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved) |

**R G C N THORACIC**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pericardiectomy for tumor and pneumectomy (1,2,7,10,13)                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rib resection (1,2,5,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoracentesis, puncture of pleural cavity for aspiration (1,2,5,6,7,10,13) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoracoplasty (1,2,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thoracotomy for oncologic resection (1,2,7,10,13)                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tube thoracostomy, includes water seal (1,2,5,6,7,10,13)                   |

**R G C N VASCULAR SYSTEM**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arterial catheterization or cannulation for sampling, monitoring or transfusion (1,2,5,6,7,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Carpal Tunnel Release (1,2,3,7,8,9,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Contrast injection for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report (1,2,7,8,9,10,13) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insertion of cannula for hemodialysis, other purpose (1,2,3,7,8,9,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insertion of peritoneovenous shunt (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insertion of tunneled centrally inserted central venous access device, with subcutaneous port (age 5 years or older) (1,2,3,5,6,7,8,9,10,13)                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insertion of tunneled centrally inserted central venous catheter (1,2,3,5,6,7,8,9,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ligation of varicose veins (1,2,7,8,9,10,13)   |

# LEHIGH VALLEY HEALTH NETWORK

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**R   G   C   N   VASCULAR SYSTEM**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Venous anastomosis, open; portocaval (1,2,7,10,13) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Venous anastomosis, open; renoportal (1,2,7,10,13) |

**R   G   C   N   ENDOSCOPY**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchoscopy* (1,2,5,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colonoscopic placement of expandable stents* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding* (1,2,5,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colonoscopy, flexible, proximal to splenic flexures; diagnostic* (1,2,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colonoscopy, flexible, proximal to splenic flexures; with biopsy or polypectomy* (1,2,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Esophagogastroduodenoscopy (EGD)* (1,2,5,7,8,9,10,13) (*Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Esophagoscopy, rigid or flexible* (1,2,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fecal Microbiota Transplant (1,2,3,7,8)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Transoral Incisionless Fundoplication* (1,2,3,7,8,10,13) (Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopic laser ablation of tumors* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopic placement of expandable stents* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopy including esophagus, stomach and either duodenum and/or jejunum as appropriate; with balloon or fixed dilation of esophagus or gastrojejunal anastomosis* (1,2,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopy including esophagus, stomach and either duodenum and/or jejunum as appropriate; with insertion of guide wire followed by dilation of esophagus over guide wire* (1,2,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate with dilation of gastric outlet for obstruction* (1,2,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)                             |

**LEHIGH VALLEY HEALTH NETWORK**  
**CLINICAL PRIVILEGES IN GENERAL SURGERY**

Initial       Renewed   
 Effective from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_

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**R   G   C   N    ENDOSCOPY**

- |                          |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate with directed placement of percutaneous gastrostomy tube/jejunostomy tube* (1,2,5,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps, bipolar cautery or snare technique* (1,2,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique* (1,2,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method* (1,2,5,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia for treatment of gastroesophageal reflux disease* (1,2,7,9,10,13) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal endoscopy with endoscopic revision of gastrojejunal anastomosis* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper gastrointestinal wireless camera endoscopy* (1,2,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved)   |

**R   G   C   N    BARIATRIC SURGERY**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endoscopic restrictive bariatric procedures* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy to limit absorption* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopic revision of bariatric procedure* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, surgical, gastric restrictive procedure, longitudinal gastrectomy (sleeve gastrectomy)* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)  |

**LEHIGH VALLEY HEALTH NETWORK**  
**CLINICAL PRIVILEGES IN GENERAL SURGERY**

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**R   G   C   N   BARIATRIC SURGERY**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Placement of intragastric balloon* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Repositioning of gastric restrictive device* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Revision, open, of gastric restrictive procedure for morbid obesity* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved) |

**R   G   C   N   PEDIATRIC SURGERY**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Circumcision of male infants (1,2,7,8,9,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endoscopy privileges for pediatric surgeons* (1,2,9,10,13) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hernia repair, pediatric (1,2,7,8,9,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Peripheral venous cutdown (1,2,7,8,10,13)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Umbilical artery catheterization (1,2,7,10,13)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vein catheterization (1,2,7,8,10,13)   |

**R   G   C   N   SURGICAL ONCOLOGY**

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal hysterectomy (1,2,3,7,13) (with approval of Chair of Obstetrics and Gynecology)                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cystotomy (1,2,7,10,13) (with approval of Chief of Urology)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heated Intraperitoneal Chemotherapy (HIPEC)* (1,2) (*Must satisfy certain credentialing criteria to be approved) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Isolated limb infusion* (1,2) (*Must satisfy certain credentialing criteria to be approved)                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laryngectomy (1,2,7,10,13) (with approval of Chief of Otolaryngology-Head & Neck Surgery)                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Oophorectomy (1,2,3,7,10,13) (with approval of Chair of Obstetrics and Gynecology)                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Salpingectomy (1,2,3,7,10,13) (with approval of Chair of Obstetrics and Gynecology)                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vulvectomy (1,2,7,10,13) (with approval of Chair of Obstetrics and Gynecology)                                   |



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**R G C N TRANSPLANTATION SURGERY**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arteriovenous (AV) fistula - creation, revision, ligation (1,2,3,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arteriovenous (AV) graft - insertion, revision, removal (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excision saphenous or other vein for vascular graft (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insertion, revision and removal of peritoneal catheter and treatment of complications (1,2,3,7,8,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nephrectomy - bilateral (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nephrectomy - unilateral (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nephrectomy - laparoscopic (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transplant nephrectomy (1,2,7)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreas transplantation and related procedures (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal biopsy - open (1,2,7,10)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal biopsy - percutaneous (1,2,7,10,13)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal transplant, auto transplant (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal transplant from deceased donor (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal transplant from living donor (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transplantation related procedures - vascular reconstruction and urinary reconstruction (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound guided transplant biopsy (1,2)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venous access including ports, tunneled and temporary venous catheters (venous catheterization) (1,2,3,7,8,10,13)

**R G C N OTHER**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	daVinci STM Robotic System-Assisted Multi-Port Laparoscopic Procedure* (1,2,10,13) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	daVinci STM Robotic System-Assisted Single-Site Laparoscopic Procedure* (1,2,10,13) (*Must satisfy certain credentialing criteria to be approved)

**LEHIGH VALLEY HEALTH NETWORK**  
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**R   G   C   N   OTHER**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluoroscopy privileges* (1,2,3,5,6,7,8,10,13) (Additional requirements as necessary as per the Medical Physicist/Radiation Safety Officer) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Implanted Loop Recorder** (1,2,7, 10,13) (**Applicant must satisfy certain credentialing criteria to be approved for this privilege.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laser* (1,2,7,10,13) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moderate Sedation - Pediatric (birth - 25 years)*** (1,2,3,5,6,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moderate Sedation - Adult* (13 years or older)*** (1,2,3,5,6,7,8,10,13) (*Must satisfy certain credentialing criteria to be approved)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiofrequency Ablation of Neoplasms* (1,2,10,13) (*Must satisfy certain credentialing criteria to be approved)

# LEHIGH VALLEY HEALTH NETWORK

CEDAR CREST & I-78 PO BOX 689

ALLENTOWN, PA 18105-1556

## CLINICAL PRIVILEGES IN GENERAL SURGERY

Name \_\_\_\_\_

### Privileges by Location:

- 1 – LVH-Cedar Crest
- 2 – LVH-Muhlenberg (includes the Behavioral Health Center and Cancer Center)
- 3 – LVH-17th & Chew (includes TSU)
- 5 – LVH-Tilghman
- 6 – LVHN Surgery Center-Tilghman
- 7 – LVH-Hazleton
- 8 – Health and Wellness Center at Hazleton
- 9 - LVHN Children's Surgery Center
- 10 - LVH-Schuylkill East Norwegian
- 11 - LVH-Schuylkill South Jackson
- 13 - LVH-Hecktown Oaks
- 14 - LVH-Coordinated Health - Allentown
- 15 - LVH-Coordinated Health - Bethlehem
- 16 - LVHN Ambulatory Surgery Center of Lopatcong, Inc
- 17 - LVHN East Stroudsburg Ambulatory Surgery Center
- 18 - LVH-Pocono

# LEHIGH VALLEY HEALTH NETWORK

## CLINICAL AREA GENERAL SURGERY

Name \_\_\_\_\_

### Acknowledgement of Practitioner

I hereby request the privileges noted.

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### \*\*\*Recommendations\*\*\*

I have reviewed the request for clinical privileges and supporting documentation and

Recommend As Requested       Recommend with Exceptions       Do Not Recommend  
the privileges requested above.

### EXCEPTIONS

Exception to Privilege:	Conditions/Modifications

Explanation:

### SUPERVISING PHYSICIAN (AHPs ONLY)

_____	_____	____/____/____
Title	Signature	Date
_____	_____	____/____/____
Title	Signature	Date
_____	_____	____/____/____
Title	Signature	Date
_____	_____	____/____/____
Title	Signature	Date
_____	_____	____/____/____
Title	Signature	Date

