Suffolk Surgery Center

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(631) 205-9090 • Fax (631) 205-9257

Delineation of Privileges
Gastroenterology

Please indicate by a check in the requested column those privileges that are commensurate with your clinical ability, training and experience for which you are applying.

Requested Privileges	FOR OFFICE USE ONLY Approved	Denied
☐ Esophagoscopy with biopsy		
☐ Esophagoscopy without biopsy		
☐ Gastroscopy with biopsy		
☐ Gastroscopy without biopsy		
☐ Sigmoidoscopy with biopsy		
☐ Sigmoidoscopy without biopsy		
☐ Colonoscopy with polypectomy		
☐ Colonoscopy without polypectomy		
☐ Small Intestine Biopsy		
☐ Esophageal dilatation		
☐ All Endoscopic Hemostatic Procedures		
☐ OTHER:		

I, _____

hereby request privileges in the specialty of Gastroenterology as indicated. I understand that privileges requested may differ from those approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

_____ _____

Physician (Signature) **Date**

APPROVAL

FOR OFFICE USE ONLY

My recommendation in regard to clinical privileges and membership is based on review and evaluation of relevant verified education, training or experience, current licensure, current competence and the applicant's ability to exercise clinical privileges requested.

☐ Qualified to receive Medical Staff membership and clinical privileges as requested.

☐ Qualified to receive Medical Staff membership and clinical privileges with changes noted:

_____

☐ Not qualified to receive Medical Staff membership and clinical privileges as requested:

_____

_____ _____

Medical Director **Date**