



**Procedures that can be performed on inpatients or outpatients**

**For procedures circled, you must provide the number of procedures performed in the**

	<u>Last 12 months</u>	<u>Last three years</u>
33. Sclerosis of esophageal varices	_____	_____
34. Banding esophageal varices	_____	_____
35. Gastroscopy and biopsy	_____	_____
36. Liver biopsy	_____	_____
37. Peritonescopy and biopsy	_____	_____
38. Small intestine biopsy	_____	_____
39. Transduodenal cannulation of pancreatic & common bile ducts	_____	_____
40. Transendoscopic polypectomy	_____	_____
41. Use of lasers	_____	_____
42. Dialysis (kidney), Peritoneal dialysis	_____	_____
43. Hemodialysis	_____	_____
44. Joint aspiration	_____	_____
45. Lumbar puncture	_____	_____
46. Needle biopsy or aspiration of bone marrow	_____	_____
47. Paracentesis	_____	_____
48. Thoracentesis	_____	_____
49. Needle aspiration of lung	_____	_____
50. Needle biopsy of lung	_____	_____
51. Needle biopsy of pleura	_____	_____
52. Bronchoalveolar lavage	_____	_____
53. Emergency endotracheal intubation	_____	_____
54. Other (identify)	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**For interpretation circled you must provide the number of interpretations performed in the**

<b><u>INTERPRETATIONS:</u></b>	<u>Last 12 months</u>	<u>Last three months</u>
55. EKG interpretations	_____	_____
56. Interpretations for bone mineral densitometry	_____	_____
57. Interpretations for bone marrow aspirate smear	_____	_____
58. Interpretations of non-invasive procedures, such as, echo, phono and apex caridography	_____	_____
59. Pulmonary Function Test (PFT)	_____	_____

New York State License # \_\_\_\_\_  
 New York Triennial Registration # \_\_\_\_\_ Expiration Date \_\_\_\_\_  
 DEA License # \_\_\_\_\_ Expiration Date \_\_\_\_\_  
 Board Certification \_\_\_\_\_ Date \_\_\_\_\_  
 Board Certification (Subspecialty) \_\_\_\_\_ Date \_\_\_\_\_

**Note:** Specific privileges will be approved only if a meaningful number of procedures or interpretations have been performed over the previous three year period.

PRINT YOUR NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ (DATE) \_\_\_\_\_

APPROVED, DIVISION CHIEF: \_\_\_\_\_ (DATE) \_\_\_\_\_

APPROVED, DIRECTOR MEDICAL SERVICE: \_\_\_\_\_ (DATE) \_\_\_\_\_