

Please list any limitations or comments you may have on a separate sheet

IDENTIFYING INFORMATION	Last Name	First name	Middle name	Previous Surname
				Date of Birth
CERTIFICATIONS	<input type="checkbox"/> BLS expires: _____	<input type="checkbox"/> ACLS expires: _____	<input type="checkbox"/> PALS expires: _____	<input type="checkbox"/> NRP expires: _____
POPULATIONS WORKED WITH	<input type="checkbox"/> Adult	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Neonate	
AREAS OF INTEREST	<input type="checkbox"/> Office based/outpatient		<input type="checkbox"/> Hospital based/inpatient	
SCOPE OF PRACTICE <i>Please be aware that this form constitutes your application to be credentialed for specific areas and procedures while on assignments through CompHealth.</i> <i>The Credentialing Committee may not consider for approval clinical capabilities where a box is not checked, or where indicated, a number is not provided.</i>	<u>Please check the box indicating which clinical capabilities you are able to perform, and where indicated, list the approximate number performed within the last 24 months.</u>			
	<input type="checkbox"/> General urology*			
	Surgeries / Procedures			
	<input type="checkbox"/> Advanced endoscopic techniques #	<input type="checkbox"/> Renal and bladder ultrasound #		
	<input type="checkbox"/> Percutaneous nephrolithotomy #	<input type="checkbox"/> w/biopsy		
	<input type="checkbox"/> Ureterscopy #	<input type="checkbox"/> TRUS biopsies #		
	<input type="checkbox"/> Radical cystectomy w/ileo-loop conduit #	<input type="checkbox"/> Fertility work-up		
	<input type="checkbox"/> Radical prostatectomy #	<input type="checkbox"/> Incontinence procedures #		
	<input type="checkbox"/> Laparoscopic surgeries #	<input type="checkbox"/> Penile prosthesis #		
	<input type="checkbox"/> Nephrectomy	<input type="checkbox"/> Extracorporeal Shock Wave Lithotripsy (ESWL)		
	<input type="checkbox"/> Prostatectomy	<input type="checkbox"/> Brachytherapy		
	<input type="checkbox"/> Pelvic node dissection	<input type="checkbox"/> Renal transplant surgery #		
	<input type="checkbox"/> Adrenalectomy #	<input type="checkbox"/> Advanced pediatric surgery* #		
	<input type="checkbox"/> Laser certification (specify type)			
* DEFINITIONS: <i>General – eval. and mgmt. of patients with urologic disorders. This may include performance of cystoscopy, transurethral surgeries (TURP, TURBT, bladder calculi fragmentation, etc.), nephrectomy, vasectomy, varicoceles, hydroceles, circumcision, orchidopexy, chordee repair, etc.</i> <i>Advanced pediatric surgery –pyeloplasty, epispadias, hypospadias repair, gender assignment</i>				

I affirm that all information given on this page is true and accurate.

Initials _____ Date _____