VANDERBILT UNIVERSITY MEDICAL CENTER
REQUEST FOR CLINICAL PRIVILEGES
Screening and Surveillance Colposcopy

Practitioners Name: ____________________________ Specialty: ____________________________

PRIVILEGING REQUIREMENTS:
In accordance with the Medical Center Medical Staff Bylaws and Department of Obstetrics / Gynecology policy, a practitioner must be credentialed and privileged to perform Screening and Surveillance Colposcopy on obstetric /gynecologic patients seen through the services at the Vanderbilt Obstetrics / Gynecology clinics. In order to be privileged, a practitioner must meet the following requirements:

1. Complete the pre-requisite education and training as set forth by the Department of Obstetrics and Gynecology.

2. Provide documented evidence of such education and training to include:
   - Certificate of Completion from an ASCCP/ACCME-accredited basic colposcopy course or comparable didactic program
   - Evidence of previous Screening and Surveillance Colposcopy experience or successful completion of a colposcopy mentorship program through ASCCP or similar precepted clinical experience
   - Attestation of competency by supervising/mentoring physician, advanced practice nurse, or physician assistant. Candidates with previous experience will demonstrate competency with a minimum of 10 supervised colposcopies on-site, prior to applying for privileging.
   - Evidence of competency (Log of procedures performed or comparable data)
   - Procedure protocol

And:
Be currently Board Certified as an advanced practice nurse or physician assistant with specialty certification and experience in:
- Gynecology; or
- Obstetrics; or
- Gynecologic Oncology; or
- Nurse-Midwifery; or
- Women’s Health; or
- Family Nurse Practitioner dependent on practice specialty and experience

In order to be recertified, one must reapply at each reappointment, providing evidence of current certification and evidence of continued competency.

Attach required documentation as explained above.

Requesting Practitioner: ____________________________ Date: ____________________________

Attestation: I have instructed, observed, and supervised ____________________________ in the performance of the requested procedure and attest that he/she is competent to perform the procedure independently.

Attesting Physician, Nurse Practitioner or Physician Assistant: ____________________________ Date: ____________________________

Department Chairman: ____________________________ Date: ____________________________

Please forward completed form with supporting documentation to:

Provider Support Services
4163 Village at Vanderbilt (8678)
Fax 936-6095

Diagnostic Colposcopy
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