Adventist Health 港安 Hong Kong Adventist Hospital Stubbs Road

APPLICATION FOR GASTROINTESTINAL ENDOSCOPY PRIVILEGE

No. of G. I. Endoscopy performed: (Please indicate No. performed)

		Numbers	Year-Year
1. Esophagogastroduodenoscopy	Diagnostic:		
	Therapeutic:		
2. Colonoscopy	Diagnostic:		
	Therapeutic:		
3. Endoscopic retrograde cholangiopancreatogarphy (ERCP)	Diagnostic:		
	Therapeutic:		

No. of Other therapeutic procedures performed:

	Numbers	Year-Year
1. PEG tube insertion		
2. Others:		

Name, address & contact number of referees (at least two GI Endoscopists):

1. _____

2. _____

Signature of Applicant: _____

Name of Applicant: _____

Date: _____

Privilege Status (For committee member use only):

☐ Accept

☐ Decline

☐ Selective privilege: _____

Committee member signature: 1._____(_____)

2._____(_____)

Date approved: _____