

Training/Credentialing

7. Did you receive training in bariatric surgery through a:
- Residency Number of bariatric procedures performed_____
 - Fellowship Number of bariatric procedures performed_____
 - Preceptorship Number of bariatric procedures performed_____
8. Are you Board certified by the American Board of Surgery? Yes No
If no, are you Board Eligible with the American Board of Surgery? Yes No
9. Are you a member of the American Society for Bariatric Surgery (ASBS)? Yes No

Hospitals/Facilities

10. Do you have:
- Full open WLS privileges Yes No
 - Full laparoscopic WLS privileges Yes No
 - Provisional open WLS privileges Yes No
 - Provisional laparoscopic WLS privileges Yes No
11. Are you credentialed to perform gastrointestinal and biliary surgery? Yes No
12. Please list all facilities where you are currently credentialed to perform open and/or laparoscopic bariatric surgery or to which you are applying for such privileges:

(Please attach proof of credentialing.)

Full laparoscopic privileges

Full open privileges

13. Do all of the above facilities provide:

- Pre-testing, recovery, ICU and diagnostic services appropriate for weight loss surgery (WLS) patients? Yes No
- Designated anesthesiology and OR teams for WLS patients? Yes No
- Anesthesiology and critical care resources for 24/7 coverage of WLS patients by attending level staff? Yes No
- On-Site specialists (in gastroenterology, general surgery, pulmonology, cardiology, infectious diseases, psychiatry) to educate, evaluate and manage WLS patients? Yes No
- Emergency Medicine services adequate for post-surgical WLS patients who may present with surgical complications? Yes No
- An integrated program for WLS patients, including specialized nursing care, dietary instruction, counseling, etc. Yes No

Coverage/Follow-up

14. Please list the names and qualifications of the bariatric surgeons who provide coverage for your practice:

<u>Name</u>	<u>Qualifications</u>
_____	_____
_____	_____
_____	_____
_____	_____

15. Is your bariatric practice affiliated with an integrated program that provides for the prevention, monitoring and management of complications? Yes No

If yes, please describe: _____

16. Describe your follow-up program (including the length of the follow-up time period) for patients for whom you have performed bariatric surgery.

Signature

Date

Print Name

Policy Number (if applicable)