

### **Application to be Listed on the Registry**

The Council of Gynecologic Endoscopy (CGE) was established to recognize expertise and to promote high quality standards in operative endoscopic surgery performed by gynecologists. Gynecologic surgeons who can demonstrate sufficient case documentation may apply.

**Criteria** – All recognized specialists in obstetrics and gynecology, e.g., certified by the American Board of Obstetrics and Gynecology (USA), the Royal College of Obstetricians and Gynaecologists (U.K.) or an equivalent certificate from the country in which they reside are eligible to be listed on the registry.

**Registry Period** – At the end of five years, all applicants must reapply for registry listing.

**Requirements** – Completed application form, operative case lists, documentation of training, board certification and letters of recommendation. All fields, forms and supporting documentation indicated on the application must be typed and submitted in English. No partial or incomplete applications will be accepted.

**Letters of Recommendation** – Two letters of recommendation will be required; one from the Department Head or Chief of Staff and one from a physician **not in practice with the applicant**. Additional information regarding the candidate may be obtained by the Council through written or verbal communication as needed.

**Refunds** – Once an application has been submitted, and all supporting materials received, only then will an application be forwarded to the council for review. Once the council has received the application, fees are no longer refundable.

### **Application Process Outline**

1. Complete and submit application with cases lists and applicable fees
2. Once submitted and payment is accepted, applicant will be notified, to provide supporting case list documentation.
3. Application is submitted for review process. (Note: Applicant may be required to submit additional documentation)
4. A letter of acceptance with certificate or denial will be sent to the applicant.

Please allow a minimum of 4-6 weeks for processing.

Application fees for each certificate requested must be in U. S. funds and are not refundable.

## Operative Laparoscopy Case Lists

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You must first determine at which practice level you wish to apply. The case lists must consist of 25 operative Laparoscopic procedures performed **within the previous 24 months** in the practice level or higher for which you are applying. The applicant must have performed two or more types of procedures in the practice level being requested. Not more than 15 cases may be of any one type and the majority of the cases must be within the Practice Level for which you are applying. The case lists must be certified by the medical records administrator of each hospital and typed on the attached CGE case list forms. **Do not list diagnostic procedures.** Practice levels are:

### Practice Level A

1. Endometriosis surgery — AFS stage I
2. Sterilizations
3. Minor adhesiolysis
4. Ovarian or peritoneal biopsy
5. Ovarian drilling
6. Ectopic pregnancy
7. Salpingectomy

### Practice Level B

1. Moderate adhesiolysis
2. Moderate endometriosis – AFS stage II or III
3. Removal of ovary
4. Ovarian cystectomy — complex (dermoid, endometrioma, etc)
5. Myomectomy for serosal and subserosal tumors
6. TLH, LAVH, LSH

**Practice Level C** – Please note in order to qualify for any Practice Level C category, all 25 cases submitted must be found in a Practice Level C procedure list. If the intent of your application is to be considered for Category 2, 3 or 4, then at least 20 of your 25 cases must meet the requirements of the Category for which you are applying.

### Category 1 – General Gynecology Procedures:

1. Myomectomy – Removal of at least 1 large fibroid of > 5 cm by ultrasound or MRI or weight of excised lesion > 75 gms, deep intramural, requiring suturing of myometrial defect with 2 or more layer closure.
2. TLH or LSH – uterine weight > 150 gms or associated with severe endometriosis and/or adhesions
3. Complex ovarian cystectomy/oophorectomy – Ovarian lesion > 6 cm by ultrasound or MRI excised with preservation of ovarian cortex or lesion associated with severe endometriosis and/or adhesions

### Category 2 – Fertility Enhancement Surgery Procedures:

4. Tubal Reanastomosis or cuff salpingostomy with delicate (<5-0) suturing
5. Extensive tubo-ovariolysis and fimbriolysis
6. Management for severe endometriosis with preservation of fertility (AFS stage III or IV)

### Category 3 – Repair of Pelvic Floor Defects & Urogynecology Procedures:

7. Bladder suspension, all methods
8. Complex repair of pelvic floor defects

### Category 4 – Gynecologic Oncology Procedures:

9. Lymphadenectomy
10. Radical Hysterectomy
11. Complex Debulking > 20 lesions

## Operative Hysteroscopy Case List

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You must first determine at which practice level you wish to apply. The case lists must consist of **15** operative hysteroscopic procedures performed **within the previous 24 months** in the practice level or higher for which you are applying. The applicant must have performed **two or more** types of surgical procedures in the practice level being requested. Not more than 11 of the cases may be of any one type. **Do not list diagnostic procedures.** Practice levels are:

### Practice Level A

1. Diagnostic with direct biopsies
2. Endometrial Polypectomy
3. IUD/foreign body removal

### Practice Level B

1. Tubal cannulation/sterilization
2. Corporeal septolysis
3. Adhesiolysis
4. Submucosal myomectomy (pedunculated)

### Practice Level C

1. Adhesiolysis — (extensive)
2. Resectoscopic endometrial ablation and/or resection
3. Submucosal myomectomy (at least 1 1/2 cm with intramural component) — completely removed
4. Septolysis of complete uterine septum with septate cervix

**Case Documentation** — Reports **should not** be sent with this application. The history and physical exam, operative and pathology reports of four randomly chosen cases from your laparoscopy case list: and/or three randomly chosen cases from hysteroscopy case list will be requested **AFTER** your case lists(s) have been received. The applicant will be notified by the CGE as to which cases will be required to complete this

application. Additional reports may be subsequently requested.

**The Council of Gynecologic Endoscopy**

*A Professional Interest Partner of the AAGL*

Application to be listed on the Registry

6757 Katella Avenue, Cypress, CA 90630-5105 • Telephone: (714) 503-6200 FAX: (714) 503-6202

**Application should include:**

___ Copy of Board Certification	___ Hospital(s) of Practice	___ Consent & Release for Inquiry	___ \$500 USD — Laparoscopy Certificate
___ Copy of Current License	___ CME (Endoscopy Only)	___ Case List Forms	___ \$500 USD — Hysteroscopy Certificate
___ Curriculum Vitae	___ References		___ \$750 USD — Laparoscopy & Hysteroscopy Certificates

**Failure to accurately complete this application will result in the delay of the processing of your application.**

*Applications that are not typed will be returned.*

**I. Personal Data**

Name (Last, First, Middle) \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Birthplace \_\_\_\_\_ Country \_\_\_\_\_ Citizenship \_\_\_\_\_

Medical Doctor/MD  (Check One) Doctor of Osteopathy

Primary Office Address \_\_\_\_\_

Office City/State/Zip \_\_\_\_\_

Telephone (include area code) \_\_\_\_\_ Fax (include/area code) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Home Address \_\_\_\_\_

Home City/State/Zip \_\_\_\_\_

Telephone (include area code) \_\_\_\_\_ Fax (include area code) \_\_\_\_\_

**II. Licensure & Certification**

Licensed to practice medicine in: State \_\_\_\_\_ License # \_\_\_\_\_ Date \_\_\_\_\_

State \_\_\_\_\_ License # \_\_\_\_\_ Date \_\_\_\_\_

Board Certification in Ob/Gyn \_\_\_\_\_ Certificate # \_\_\_\_\_ Date \_\_\_\_\_

Or Equivalent International Certificate \_\_\_\_\_ Certificate # \_\_\_\_\_ Date \_\_\_\_\_

Board Certification Subspecialty \_\_\_\_\_ Certificate # \_\_\_\_\_ Date \_\_\_\_\_

Certified Other Board \_\_\_\_\_ Certificate # \_\_\_\_\_ Date \_\_\_\_\_

Recertified \_\_\_\_\_ Expires \_\_\_\_\_ Date \_\_\_\_\_

**III. Medical Education & Training**

School of Medicine \_\_\_\_\_ Degree \_\_\_\_\_ Date \_\_\_\_\_

Graduate Training \_\_\_\_\_

Type of Residency \_\_\_\_\_ Inclusive Dates \_\_\_\_\_ from/to \_\_\_\_\_

Fellowship \_\_\_\_\_ Inclusive Dates \_\_\_\_\_ from/to \_\_\_\_\_

**IV. Medical Staff Privileges**

Hospital Affiliations (last ten years) - Please have your hospital administration complete the attached form and submit it with your application. Please complete individual forms for every hospital where you have privileges.

**V. Continuing Medical Education**

The applicant must demonstrate continuing medical education in gynecologic endoscopy during the preceding 5 years. For training courses or programs or attendance at a national or international meeting on gynecologic endoscopy, please provide on page 5, course titles, location and sponsoring organization, date and number of hours received. If possible, please include copies of certificates of attendance.

If you have been part of a teaching faculty at a course, or a preceptor, please list on page 5. If you have contributed to the literature of endoscopy, either with book chapters or articles in a peer reviewed journal, please list on page 5.

**VI. Malpractice Information and Disciplinary Action/Health Status**

Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Have you had any claims filed against you, for non-obstetrical claims, within the last 10 years? No Yes. If yes, please provide the number of cases and explain in detail on a separate sheet (disposition status pending, settled, etc.).

Have you had any disciplinary action taken against you by any professional organization, hospital medical staff, third party payor or licensing body? No Yes. If yes, please explain in detail on a separate sheet.

Any mental or physical condition that may affect your ability to practice medicine? No Yes. If yes, please explain in detail on a separate sheet.

**VII. Letters of Recommendation**

Please include two letters of recommendations with your application. The letters should be from the Department Head or Chief of Staff and one from a physician not in practice with the applicant.

Application fees for each certificate requested must be in U.S. funds and are not refundable.

***Omission of information may be cause for rejection.  
The information contained in this application is true to the best of my knowledge.***

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For CGE office use only: Date application received \_\_\_\_\_  
Notification of acceptance \_\_\_\_\_

Notified application complete \_\_\_\_\_

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**CME IN ENDOSCOPY**

<b>Chapter/Articles Written</b>		
Title of Paper/Chapter	Publication	Volume Number and Date

<b>Courses Taught</b>				
Title	Location	Sponsoring Organization	Date	CME Hours

<b>Courses Attended</b>				
Title	Location	Sponsoring Organization	Date	CME Hours

*(Extra copies of this form should be photocopied as necessary)*  
**THIS FORM MUST BE COMPLETED AND RETURNED WITH YOUR APPLICATION.**

**The Council of Gynecologic Endoscopy**

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**Applicant's Consent and Release for Inquiry**

I, Dr. \_\_\_\_\_, am applying to become an associate in The Council of Gynecologic Endoscopy (ACGE). I give my permission to any institution, person or group of persons with whom I have been associated, to release to the ACGE any information pertaining to my hospital and professional conduct, to my integrity, my physical and mental health. Such information may include written material related to the revocation, reduction, denial or suspension of clinical privileges by hospital authorities, medical staff committees, medical societies, state licensing bodies or any other authoritative body.

In giving my permission for the release of such information to the ACGE, I hereby release from liability any institution, person or group of persons for their acts performed in good faith and without malice in supplying the information requested by the ACGE for the consideration and processing of my application.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

THIS FORM MUST BE COMPLETED AND RETURNED WITH YOUR APPLICATION.

# The Council of Gynecologic Endoscopy

*A Professional Interest Partner of the AAGL*

## Application to be listed on the Registry

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### Medical Staff Privileges

Dr. \_\_\_\_\_, has applied to become an associate in The Council of Gynecologic Endoscopy. The Council is investigating the practitioner pursuant to his application. Please verify whether or not this doctor is an active member of your staff and please provide the dates of privilege.

Also, please indicate if the practitioner has ever been the subject of an investigation involving professional misconduct by your institution. Such information will be kept confidential to the extent permitted by law.

Thank you for your assistance in our accreditation process.

Sincerely,  
ACGE Board of Directors

Member in good standing?  Yes  No  
Investigated for incompetence/misconduct?  Yes  No

Name (please print) \_\_\_\_\_

Title: \_\_\_\_\_

Hospital Name: \_\_\_\_\_

Hospital Address: \_\_\_\_\_

Hospital Phone: \_\_\_\_\_ Fax Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Comments:

THIS FORM MUST BE COMPLETED AND RETURNED WITH YOUR APPLICATION.

**Instructions for Completing the Case List Forms**  
*Cases **must** have been performed **within two consecutive calendar years.***  
***Case list must be submitted with your completed application.***

1. Please type your application.
2. The applicant must be listed as the primary physician on all cases submitted.
3. You must use the form supplied to submit your case list.
4. You may submit this application on line or by surface mail. If you submit on line you must fax or mail the signature pages.
5. Please note there are different forms for laparoscopy and hysteroscopy.
6. Do not list more than 25 laparoscopies and/or 15 hysteroscopies.
7. Please review the examples enclosed before starting your case list.
8. The case list numbers are assigned by you, the applicant.
9. Applicant must also number the case list forms in right lower corner.
10. Cases submitted for more than one institution should not be co-mingled. They must be listed in chronological order from each institution.
11. Surgical indication(s), the operative procedure(s) performed, and the complication(s) should be described by the descriptive abbreviations found on the key code sheets.
12. The code number for complications should be followed by a letter to indicate when it occurred (a=intra op; b=post op; c=late post op).
13. When the key code 10 (Other) is used, a brief description should be given.
14. After the receipt of your application, you will be asked to submit randomly chosen operative report, pathology reports, and history.

## OPERATIVE LAPAROSCOPY

### Surgical Indications Key

Please use abbreviations for case list as provided.

AUB - Abnormal Uterine Bleeding

CIN - Cervical Intraepithelial Neoplasia

Dysm - Dysmenorrhea

Dysp - Dyspareunia

Ectopic Pregnancy

Endo - Endometriosis

Neoplasia

Prolapse - General

Inf - Infertility

Mass - Pelvic Mass

Pain

Steril - Sterilization

Incont - Urinary Incontinence

Myoma

### PROCEDURES KEY

#### **Tubal**

- 1a. Anastomosis
- 1b. Repair-distal
- 1c. Salpingostomy
- 1d. Total salpingectomy
- 1e. Tubal Occlusion

#### **Adnexal**

- 2a. Cystectomy (*excluding ovarian endometrioma*)
- 2b. Oophorectomy
- 2c. Salpingo-oophorectomy
- 2d. Ovarian drilling

#### **Uterine-Conservation**

- 3a. Cornual Resection
- 3b. Myomectomy (myoma must be >3cm in diameter or >20 grams in weight)

#### **Hysterectomy** (*with or without adnexectomy*)

- 4a. LAVH (*must include isolation of the uterus from the IP, round ligament and bladder flap*)
- 4b. Total Laparoscopic Hysterectomy
- 4c. Supracervical Laparoscopic Hysterectomy

#### **Adhesiolysis**

- 5a. Abdominal
- 5b. Pelvic
- 5c. Pelvic-Abdominal Combined

#### **Endometriosis**

- 6a. Treatment of Stage I.
- 6b. Treatment of Stage II.
- 6c. Treatment of Stage III or IV AFS
- 6d. Stripping of Ovarian Endometrioma > 3 cm

#### **Colposuspension**

- 7a. Cystourethropexy (Burch)
- 7b. Pelvic Reconstruction

#### **Miscellaneous**

- 8a. Appendectomy
- 8b. Lymph node sampling or dissection

**Other** (please specify)

### Complications Key

- |                                |  |                            |
|--------------------------------|--|----------------------------|
| (1) Bladder Injury             | (4) Hemorrhage - ( <i>specify site &amp; EBL</i> ) | (7) Ureteral Injury        |
| (2) Bowel Injury               | (5) Immediate Laparotomy                           | (8) Hernia                 |
| (3) Fever (100.4°F or greater) | (6) Transfusion                                    | (9) Other (please specify) |

Application and for  
Practice Level:

**THE COUNCIL OF GYNECOLOGIC ENDOSCOPY**  
6757 Katella Avenue • Cypress, CA 90630 USA  
PHONE: (714) 503-6200 • FAX: (714) 503-6202

**EXAMPLE**

A

B

C  Category: 1  2  3  4  (Choose one category)

**OPERATIVE LAPAROSCOPY CASE LIST**  
(Please Type)

This is an example of how case list forms should be completed. It is the applicant's responsibility that directions are followed. Forms should be typed. Different keys exist for laparoscopy and hysteroscopy. Do not switch.

Physician Name David G. Green, M.D. Hospital Name & Address St. Joseph's Hospital, 11346 Bell Avenue, New York, NY 11306-2403  
Telephone: (212) 444-5544 Facsimile: (212) 554-6704

Case List Number (Consecutive by dates)	Hospital M.R. # Date of Adm. Date of Disch.	Patient initials Age (yrs.) Parity	List Primary Surgical Indications First	List Primary Procedures Performed First	Histology Diagnosis Size and Weight (when available)	Complications
1	45073 3 / 5 / 99 3 / 5 / 99	BV 25y / o PO	CIN	4B	CIN III, myoma 3b 4cm 16gms	a) Intra-op b) Post c) Late
2	46990 3 / 20 / 99 3 / 21 / 99	JR 25y / o P2	Mass	2a	Serous Cyst adeno 4cm 25gms	None
3	47111 4 / 7 / 99 4 / 9 / 99	PB 46y / o P1	Myoma	4c	normal uterus Tubes & ovaries 10x8x6cm 150gms	20c pneumothorax
<i>Applicant to number consecutively</i>				<i>Use indication key sheet</i>	<i>(If no specimen write none)</i>	<i>Use complications key sheet. Use appropriate letters, see instructions sheet. If none, write none.</i>

I certify that the information contained on this page is true and correct and verifiable through patient medical records.

Printed Name Susan Smith  
Medical Records Administrator

*Susan Smith*

Signature

4/6/06  
Date

(Extra copies of this form should be photocopied as necessary)

(Applicants must complete page numbers)

Application and for  
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PHONE: (714) 503-6200 • FAX: (714) 503-6202

A

B

C  Category: 1  2  3  4

(Choose one category)

**OPERATIVE LAPAROSCOPY CASE LIST**

(Please Type)

Physician Name \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Facsimile Number: \_\_\_\_\_

Hospital Name & Address \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Facsimile Number: \_\_\_\_\_

**Case List  
Number**  
(Consecutive by  
dates)

Hospital
M.R. #
Date of Adm.
Date of Disch

Patient
Initials
Age (yrs.),
Parity

List Primary Surgical Indications First

List Primary Procedures Performed First

Histology
Diagnosis
Size and Weight (when available)

Complications
a) Intra-op
b) Post
c) Late

I certify that the information contained on this page is true and correct and verifiable through patient medical records.

Printed Name \_\_\_\_\_  
*Medical Records Administrator*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

(Extra copies of this form should be photocopied as necessary)

(Applicants must complete page numbers)

Page \_\_\_\_\_ of \_\_\_\_\_

## OPERATIVE HYSTEROSCOPY

### Surgical Key Indications

Please use abbreviations for case list as provided.

Abn - Abnormal Hysterosalpingogram

PMB - Post Menopausal Bleeding

AUB - Abnormal Uterine Bleeding

Preg Waste - Pregnancy Waste

U/S - Abnormal Ultrasound

Steril — Sterilization

Inf – Infertility

FB — Foreign Body

Other (please specify)

### Procedures Key

- (1) Adhesiolysis
- (2) Endometrial Ablation/Resection (*Global endometrial ablation techniques are not acceptable*)
- (3) Endometrial Polypectomy (*Polyp must be removed by hysteroscopy*)
- (4) Endometrial Resection (partial)
- (5) Myomectomy (complete removal)
- (6) Myomectomy (partial removal)
- (7) Septolysis
- (8) Tubal Cannulation / Sterilization
- (9) Retrieval of IUD/Foreign Body
- (10) Other (please specify)

### Complications Key

- |   |  |
|---|--|
| (1) Fluid Overload  | (6) Perforation - ( <i>with intra-abdominal organ injury</i> ) |
| (2) Hemorrhage - ( <i>specify site &amp; EBL</i> )                | (7) Transfusion  |
| (3) Laparotomy - ( <i>specify reason</i> )                        | (9) Other (please specify)                                     |
| (4) Other distending media complications (specify)                |  |
| (5) Perforation - ( <i>without intra-abdominal organ injury</i> ) |  |

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EXAMPLE

A

B

C

OPERATIVE HYSTEROSCOPY CASE LIST  
(Please Type)

This is an example of how case list forms should be completed. It is the applicant's responsibility that directions are followed. Forms should be typed. Different keys exist for laparoscopy and hysteroscopy. Do not switch.

Physician Name David G. Green, M.D. Hospital Name & Address St. Joseph's Hospital, 11346 Bell Avenue, New York, NY 11306-2403  
Telephone: (212) 444-5544 Facsimile: (212) 554-6704

Case List Number (Consecutive by dates)	Hospital M.R. # Date of Adm. Date of Disch.	Patient Initials Age (yrs.) Parity	List Primary Surgical Indications First	List Primary Procedures Performed First	Histology Diagnosis Size and Weight (when available)	b) Post 3b	Complications a) Intra-op c) Late
1	79514 3 / 6 / 99 3 / 6 / 99	Vb 30y / o	CIN	4B	CIN III, myoma 4cm		
2	80544 4 / 2 / 99 4 / 2 / 99	AB 21y / o P2	Abn	4,1	None 4cm 25gms		None
3	92441 6 / 10 / 99 6 / 10 / 99	CF 78y / o	Abn U/S PMB	5,3	Endometrial Polyp 1 fix2x3 cm 6gms		2a (right lower segment; 300 cc)
<i>Applicant to number consecutively</i>				<i>Use indication key sheet</i>	<i>(If no specimen write none)</i>		<i>Use complications key sheet. Use appropriate letters, see instructions sheet. If none, write none.</i>

I certify that the information contained on this page is true and correct and verifiable through patient medical records.

Printed Name Susan Smith

*Medical Records Administrator  
(Extra copies of this form should be photocopied as necessary)*

*Susan Smith*

*Signature*

4/6/06

*Date*

(Applicants must complete page numbers)

Application and for  
Practice Level:

A   
B   
C

**THE COUNCIL OF GYNECOLOGIC ENDOSCOPY**

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PHONE: (714) 503-6200 • FAX: (714) 503-6202

**OPERATIVE HYSTEROSCOPY CASE LIST**

(Please Type)

Physician Name \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Facsimile Number: \_\_\_\_\_

Hospital Name & Address \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Facsimile Number: \_\_\_\_\_

Case List Number (Consecutive by dates)	Hospital M.R. # Date of Adm. Date of Disch	Patient Initials Age (yrs.), Parity	List Primary Surgical Indications First	List Primary Procedures Performed First	Histology Diagnosis Size and Weight (when available)	Complications d) Intra-op e) Post f) Late

**I certify that the information contained on this page is true and correct and verifiable through patient medical records.**

Printed Name

\_\_\_\_\_  
*Medical Records Administrator*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

*(Extra copies of this form should be photocopied as necessary)*

(Applicants must complete page numbers)