

SUNY Upstate University Hospital

Medical Staff Services

PROCEDURE TRACKING

Print Name: _____

CASE #	PROCEDURE*	DETAIL	COMPLICATIONS / NOTES
		Patient #: Date:	<input type="checkbox"/> Yes (please explain): _____ _____ <input type="checkbox"/> No
		Patient #: Date:	<input type="checkbox"/> Yes (please explain): _____ _____ <input type="checkbox"/> No
		Patient #: Date:	<input type="checkbox"/> Yes (please explain): _____ _____ <input type="checkbox"/> No
		Patient #: Date:	<input type="checkbox"/> Yes (please explain): _____ _____ <input type="checkbox"/> No
		Patient #: Date:	<input type="checkbox"/> Yes (please explain): _____ _____ <input type="checkbox"/> No
		Patient #: Date:	<input type="checkbox"/> Yes (please explain): _____ _____ <input type="checkbox"/> No
		Patient #: Date:	<input type="checkbox"/> Yes (please explain): _____ _____ <input type="checkbox"/> No
		Patient #: Date:	<input type="checkbox"/> Yes (please explain): _____ _____ <input type="checkbox"/> No
		Patient #: Date:	<input type="checkbox"/> Yes (please explain): _____ _____ <input type="checkbox"/> No
		Patient #: Date:	<input type="checkbox"/> Yes (please explain): _____ _____ <input type="checkbox"/> No

I certify that the above accurately reflects the cases and procedures I have performed, and submit the above as documentation of competence for the procedures I am requesting.

Signature

Date

*** If cases and procedures were proctored in order to request an increase in privilege, the proctor's name(s) must also be supplied**

Return by email (medstaff@upstate.edu) or fax (315-464-8524) to Medical Staff Services.