Obstetrics and gynecology

Background

Obstetrics and gynecology (OB/GYN) is the medical specialty that involves the treatment of clinical conditions that are specific to women. Obstetricians diagnose and manage all conditions occurring during pregnancy from the time of conception through the postpartum period. Gynecologists diagnose and treat diseases particular to the female reproductive organs.

An OB/GYN must hold a four-year college degree, a four-year medical degree, and complete residency training. Physicians must have a license to practice and may choose to become board-certified by the American Board of Obstetrics & Gynecology (ABOG) or the American Osteopathic Board of Obstetrics and Gynecology (AOBOG).

The ABOG offers the certification in the following subspecialties:

- Critical care medicine (see Clinical Privilege White Paper, Critical care medicine—Practice area 129)
- Gynecologic oncology (see Clinical Privilege White Paper, Gynecologic oncology—Practice area 112)
- Hospice and palliative medicine (see Clinical Privilege White Paper, Hospice and palliative medicine—Practice area 406)
- Maternal and fetal medicine (see Clinical Privilege White Paper, Maternal and fetal medicine—Practice area 103)
- Reproductive endocrinology and infertility (see Clinical Privilege White Paper, Reproductive endocrinology and infertility—Practice area 195)

The AOBOG offers certification in maternal and fetal medicine, reproductive endocrinology, and gynecologic oncology.

While there are other practitioners who request OB/GYN privileges, this paper focuses on physicians who have completed residency training in OB/GYN. For additional information, see Clinical Privilege White Paper, Family Practice—Practice area 134, and Clinical Privilege White Paper, Nurse-midwife—Practice area 164.
Involved specialties

Obstetricians, gynecologists

Positions of specialty boards

**ABOG**

The ABOG is an independent, nonprofit organization that certifies obstetricians and gynecologists in the United States. The American Board of Medical Specialties recognizes the specialty board.

To become board-certified, a physician must pass a written test to demonstrate that he or she has obtained the knowledge and skills required for the medical and surgical care of women. He or she must also show experience in treating women’s health-care prior to the oral examination, which tests the physician’s skills, knowledge, and ability to treat different conditions. The test examiners also review the patients the physician has treated during the past year.

Physicians must meet the annual requirements of the ABOG for maintenance of certification and recertify every 10 years.

**AOBOG**

The AOBOG is an approved specialty board of the American Osteopathic Association (AOA). The AOBOG certifies osteopathic obstetricians and gynecologists in the United States.

Physicians who receive initial certification after June 1, 2002, are required to recertify every six years. Physicians certified prior to that date do not require recertification.

Candidates for certification must pass both a written and oral examination.

Candidates for the written examination must meet the following criteria:

➤ Be a graduate of an AOA-accredited college of osteopathic medicine

➤ Be a postgraduate year four resident in, or a graduate of, an AOA- or an Accreditation Council for Graduate Medical Education (ACGME)-approved postdoctoral training program in OB/GYN

Candidates for the oral examination must meet the following criteria:

➤ Have passed the AOBOG written examination

➤ Have received approval from the American College of Osteopathic Obstetricians and Gynecologists (ACOOG) for all years of osteopathic OB/GYN training
 Positions of societies, academies, colleges, and associations

**ACOG**

The American College of Obstetrics and Gynecology (ACOG) is the nation’s leading group of professionals who provide healthcare to women. The private, voluntary, nonprofit organization currently has over 52,000 members.

To become a member of the ACOG, applicants must meet the following requirements:

- Be board-certified in OB/GYN
- Complete an OB/GYN residency program
- Have an active license to practice medicine
- Have practiced obstetrics and/or gynecology for the five years immediately prior to the date of the application
- Have practiced in the same community for a minimum of 12 months prior to the submission of an application
- Have attained high ethical and professional standing
- Have two endorsements from active fellows of the ACOG

**ACOOG**

The ACOOG educates and supports osteopathic healthcare professionals to improve the quality of life for women. Members of ACOOG have completed four years of medical school, a one-year internship, and four years of specialty training in OB/GYN. They must also be members in good standing of the AOA.

To become certified in OB/GYN, ACOOG states that doctors of osteopathic medicine (DO) must pass special oral and written examinations by the AOBOG.

**ACGME**

The ACGME has published program requirements for graduate medical education in OB/GYN (effective January 1, 2008). In this document, the ACGME states that resident education in OB/GYN must include four years of accredited, clinically oriented...
graduate medical education. It must be focused on reproductive healthcare and ambulatory primary healthcare for women, including health maintenance, disease prevention, diagnosis, treatment, consultation, and referral.

In regard to obstetrics competencies, the ACGME states that residents must develop competencies in the following areas:

- The full range of obstetrics, including medical and surgical complications of pregnancy and experience in the management of critically ill patients
- Genetics
- Learning and performing operative vaginal deliveries
- Performing breech and multi-fetal deliveries
- Performing vaginal births after previous cesarean delivery
- Learning the principles of general and conduction anesthesia, together with the management and complications of these techniques
- Immediate care of the newborn
- The full range of commonly employed obstetrical diagnostic procedures
- The emotional and psychosocial impact of pregnancy or pregnancy loss on an individual and her family
- The counseling of women regarding nutrition, exercise, health maintenance, high-risk behaviors, and preparation for pregnancy and childbirth
- Obstetric pathology

In regard to gynecology competencies, the ACGME states that residents must develop competencies in the following areas:

- The full range of medical and surgical gynecology for all age groups, including experience managing critically ill patients
- Diagnosis and management of pelvic floor dysfunction
- Diagnosis and medical and surgical management of urinary incontinence
- Oncology, including prevention, diagnosis, and treatment
- Diagnosis and nonsurgical management of breast disease
- Reproductive endocrinology and infertility
- Clinical skills in family planning
- Psychosomatic and psychosexual counseling
- The full range of commonly employed gynecologic diagnostic procedures
Counseling and educating patients about normal physiology of the reproductive tract and about high-risk behaviors that may compromise reproductive function

Gynecologic pathology

In regard to primary and preventive care competencies, the ACGME states that residents must develop competency in comprehensive history taking, including medical, nutritional, sexual, family, genetic, and social behavior data and the ability to assess health risks.

AOA

The AOA serves as the professional organization for all DOs and osteopathic medical students. In addition to serving as the primary certifying body for DOs, the AOA is the accrediting agency for all osteopathic medical colleges and healthcare facilities.

All AOA board-certified physicians must:

- Be a member of the AOA or the COA
- Pay the annual certification registration fee
- Maintain a minimum of 120 hours of approved and documented AOA continuing medical education credits within a three-year period, at least one-third of which must be in the physician’s general specialty

The AOA grants certification in OB/GYN through the AOBBOG.

The AOA publishes a document titled Basic Standards for Osteopathic Training in Obstetrics and Gynecology. The document contains the basic standards for residency training in OB/GYN as approved by the AOA and the ACOOG.

The residency program in OB/GYN can be either four years in duration following completion of an AOA-approved rotating internship or three years in duration following the completion of an AOA-approved specialty track internship in OB/GYN. Each program shall include training in gynecology, obstetrics, perinatology, genetics, endocrinology, infertility, family planning, human sexuality, oncology, psychosomatics, ultrasound, and all other means of diagnosis and treatment through didactic and clinical experience. The integration of osteopathic philosophy, principles, and practice should be an ongoing feature of the resident’s training and experience.
Basic science training should emphasize the relationships of anatomy, pathology, physiology, biochemistry, and bacteriology as they relate to OB/GYN.

All resident training programs shall consist of a minimum of 48 months of postgraduate training and shall provide, at a minimum, training in the following areas:

➤ Obstetrics
➤ Gynecologic surgery/gynecology
➤ OB/GYN ultrasound
➤ Operative laparoscopy/hysteroscopy
➤ Care of the newborn
➤ Pathology/cytology
➤ Maternal-fetal medicine/genetics
➤ Gynecological oncology
➤ Reproductive endocrinology
➤ Urogynecology
➤ Ambulatory gynecology

Positions of accreditation bodies

CMS has no formal position concerning the delineation of privileges for OB/GYN. However, the CMS Conditions of Participation (CoP) define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules, or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

➤ Individual character
➤ Individual competence
➤ Individual training
➤ Individual experience
➤ Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”
Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

The Joint Commission (formerly JCAHO) has no formal position concerning the delineation of privileges for OB/GYN. However, in its Comprehensive Accreditation Manual for Hospitals, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and
implementing a privileging process.” It goes on to state that this process typically includes:

➤ Developing and approving a procedures list
➤ Processing the application
➤ Evaluating applicant-specific information
➤ Submitting recommendations to the governing body for applicant-specific delineated privileges
➤ Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
➤ Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for standard MS.06.01.05 include several requirements as follows:

➤ The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
➤ Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
➤ Consistent application of criteria
➤ A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
➤ Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform the privileges requested
➤ A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
➤ Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)

A process to determine whether there is sufficient clinical performance information to make a decision related to privileges

A decision (action) on the completed application for privileges occurring within the time period specified in the organization’s medical staff bylaws

Updating of information regarding any changes to practitioners’ clinical privileges as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting
from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

**HFAP** The Healthcare Facilities Education Program (HFAP) has no formal position concerning the delineation of privileges for OB/GYN. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges are required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileg ing
and reappointment requests from members and other creden-
tialed staff.

**DNV**

Det Norske Veritas (DNV) has no formal position concern-
ing the delineation of privileges for OB/GYN. MS.12 Standard
Requirement (SR) 1 states, “The medical staff bylaws shall
include criteria for determining the privileges to be granted to
individual practitioners and a procedure for applying the criteria
to those individuals that request privileges.”

The governing body shall ensure that under no circumstances
is medical staff membership or professional privileges in the
organization dependent solely upon certification, fellowship,
or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical
Privileges (MS.12), DNV requires specific provisions within
the medical staff bylaws for:

- The consideration of automatic suspension of clinical
  privileges in the following circumstances: revocation/re-
  striction of licensure; revocation, suspension, probation
  of a DEA registration; failure to maintain professional
  liability insurance as specified; and noncompliance
  with written medical record delinquency/deficiency
  requirements
- Immediate and automatic suspension of clinical privileges
due to the termination or revocation of the practitioner’s
  Medicare/Medicaid status
- Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for
general surgery and surgical subspecialties are acceptable as
long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to en-
sure that all individuals provide services only within the scope
of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are
for a period as defined by state law or, if permitted by state law,
not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured,
utilized, and evaluated as a part of the decision-making for ap-
pointment and reappointment. Although not specifically stated,
this would apply to the individual practitioner’s respective delineation of privilege requests.

Positions of other interested parties

In a 2009 joint statement on cooperative practice and hospital privileges, the American Academy of Family Physicians (AAFP) and the ACOG state that a cooperative and collaborative relationship among obstetricians, family physicians, and nurse midwives is essential to provide consistent, high-quality care to pregnant women. Obstetricians must be willing to provide consultation and backup for family physicians, and family physicians should determine when timely consultation and/or referral might be appropriate for a patient.

In regards to practice privileges, the position states that the assignment of hospital privileges is a local responsibility and that privileges should be granted on the basis of training, experience, and demonstrated current competence. All physicians should be held to the same standards for granting privileges, regardless of specialty.

In regards to interdepartmental relationships, the position states that privileges recommended by the department of family medicine shall be the responsibility of that department. Similarly, privileges recommended by the department of OB/GYN shall be the responsibility of that department. When privileges are recommended jointly, they shall be the joint responsibility of the two departments.

In its “Maternal/Child Care (Obstetrics)” policy, the AAFP states that maternal/child care is integral to the discipline of family medicine. The AAFP advocates that every family medicine resident be trained to provide basic maternal/child care. Family physicians are trained in the care of pregnancy and common pregnancy problems, with some receiving advanced training in maternal/child care. The scope of practice may include handling medical problems in pregnancy, care of low-risk pregnancy patients, or care of high-risk pregnancies, including performing cesarean sections.

The AAFP states that the determination of maternal care privileges should be based on the individual physician’s documented training and/or experience, demonstrated abilities, and current competence. Family physicians should evaluate fellow family physicians in credentialing and privileging determinations.
CRC draft criteria

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding OB/GYN. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strike through or delete any procedures they do not wish to request.

Minimum threshold criteria for requesting core privileges in OB/GYN

Basic education: MD or DO

Minimal formal training: Successful completion of an ACGME- or AOA-accredited residency in OB/GYN and/or current certification or active participation in the examination process leading to certification in OB/GYN by the ABOG or the AOBOG.

Required current experience: Applicants must be able to demonstrate that they have performed at least 50 deliveries (including at least five C-sections) and at least 25 gynecological surgical procedures (including at least five major abdominal cases), reflective of the scope of privileges requested, in the past 12 months, or that they have successfully completed an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

References

If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

Core privileges

Core privileges for obstetrics include the ability to admit, evaluate, diagnose, treat, and provide consultation to adolescent and adult female patients and/or provide medical and surgical care of the female reproductive system and associated disorders, including major medical diseases that are complicating factors in pregnancy. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills:
➤ Amniocentesis
➤ Amnioinfusion
➤ Amniotomy
➤ Application of internal fetal and uterine monitors
➤ Augmentation and induction of labor
➤ Cerclage
➤ Cervical biopsy or conization of cervix in pregnancy
➤ Cesarean hysterectomy, cesarean section
➤ Circumcision of newborn
➤ External version of breech
➤ Hypogastric artery ligation
➤ Immediate care of the newborn (including resuscitation and intubation)
➤ Interpretation of fetal monitoring
➤ Management of high-risk pregnancy, inclusive of such conditions as pre-eclampsia, postdatism, third-trimester bleeding, intrauterine growth restriction, premature rupture of membranes, premature labor, and placental abnormalities
➤ Management of patients with or without medical, surgical, or obstetrical complications for normal labor, including toxemia, threatened abortion, normal puerperal patient, normal antepartum and postpartum care, postpartum complications, and fetal demise
➤ Manual removal of placenta, uterine curettage
➤ Medication to induce fetal lung maturity
➤ Normal spontaneous vaginal delivery
➤ Obstetrical diagnostic procedures, including ultrasonography and other relevant imaging techniques
➤ Operative vaginal delivery (including the use of obstetric forceps and/or the vacuum extractor)
➤ Performance of breech and multifetal deliveries
➤ Performance of history and physical exam
➤ Pudendal and paracervical blocks
➤ Repair of fourth-degree perineal lacerations or of cervical or vaginal lacerations
➤ Treatment of medical and surgical complications of pregnancy
➤ Vaginal birth after previous cesarean section

Core privileges in gynecology include the ability to admit, evaluate, diagnose, treat, and provide consultation and the pre-, intra-, and postoperative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system.
and nonsurgically treat disorders and injuries of the mammary glands. Physicians may provide care to patients in the intensive care setting in conformance with unit policies. They may also assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills:

- Adnexal surgery, including ovarian cystectomy, oophorectomy, salpingectomy, and conservative procedures for treatment of ectopic pregnancy
- Aspiration of breast masses
- Cervical biopsy, including conization
- Colpocleisis
- Colpoplasty
- Colposcopy
- Cystoscopy as part of a gynecological procedure
- Diagnosis and management of pelvic floor dysfunction, including operations for its correction (e.g., repair of rectocele, enterocele, cystocele, or pelvic prolapse)
- Diagnostic and therapeutic dilation and curettage
- Diagnostic and operative laparoscopy (other than tubal sterilization)
- Endometrial ablation
- Gynecologic diagnostic procedures, including ultrasonography and other relevant imaging techniques
- Hysterectomy, abdominal and vaginal, including laparoscopically assisted
- Hysterosalpingography
- Hysteroscopy, diagnostic or ablative, excluding the use of the resection technique
- Incidental appendectomy
- Incision and drainage of pelvic abscesses
- Laparotomy (other than tubal sterilization)
- Metroplasty
- Myomectomy, abdominal
- Operation for treatment of early-stage carcinoma of the vulva, vagina, endometrium, ovary, or cervix
- Operation for treatment of urinary stress incontinence, vaginal approach, retropubic urethral suspension, and sling procedure
- Operation for uterine bleeding (abnormal and dysfunctional)
- Operations for sterilization (tubal ligation, transcervical sterilization [determine whether core or noncore])
Operative management of pelvic pain
Performance of history and physical exam
Tuboplasty and other infertility surgery (not microsurgical)
Uterosacral vaginal vault fixation, paravaginal repair
Uterovaginal, vesicovaginal, rectovaginal, and other fistula repair
Vulvar biopsy
Vulvectomy, simple

Special requests in OB/GYN

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence. Noncore privileges include:

- Use of laser
- Use of robotic-assisted system for gynecologic procedures (hysterectomy, salpingo-oophorectomy, and microsurgical fallopian tube reanastomosis)
- Transcervical sterilization (determine whether core or noncore)
- Administration of sedation and analgesia

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism.

Applicants in OB/GYN must be able to demonstrate that they have demonstrated competence and adequate volume of experience in 50 deliveries (including at least 10 C-sections) and 50 gynecological surgical procedures (including at least 10 major abdominal cases) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges. In addition, continuing education related to OB/GYN should be required.

For more information

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