وزارة الصحـــــة العامـــــة
Ministry of Public Health
State of Qatar • دولـــة قطـــر

Advanced Privileges Request Form: Oral and Maxillofacial Surgery

Privilege Request

(Dentist)

Applicant's Name: ……..…… Scope of Practice: …….

License No. (If Any): ……..…… Facility: ……..

Date: ……..……

Instructions

For applicant:

1. **Please note that you should sign next to each requested privilege.**
2. **Please use this sign (√) for the requested privilege.**
3. **Please leave any procedures you do not want to apply for blank and do not use (X) sign.**
4. **Please do not write additional privilege out of your scope of practice, as it will not be accepted.**
5. **Please do not write anything in the "for committee Use "section.**
6. **For additional privilege, do not choose the already granted privilege**
7. **Please attach the previous approval of the privilege when you apply for additional privilege.**
8. **Please note that you can apply for Appeal within one month of the date of Issuance of the Privilege.**
9. **You can only apply Once for Appeal per a single Privilege Application.**

For committee:

1. **Please note that the final decision must be signed by minimum 2 committee members.**
2. **Please use this sign (√) for recommended and not-recommended privilege.**
3. **Please specify the reasons for rejection (if applicable); for example (require experience, logbook is insufficient, need additional courses, etc.)**

T: +974 44070000
P.O. Box: 42, Doha-Qatar
ت: ٤٤٠٧٠٠٠٠ +٩٧٤
ص.ب.: ٤٢، الدوحة - قطر
www.moph.gov.qa

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Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Orthognathic surgery including Snoring and sleep apnea correction surgery.					
2. Reconstructive surgery of the face except Free flap surgery.					
3. Congenital oral and maxillofacial deformities, including Cleft lip and palate surgery					
4. Facial plastic surgery (Related to bone reconstruction cases in Oral and maxillofacial region only)					
5. Benign Oral and Maxillofacial Tumor surgery (non-reconstructive)					
6. Botox and Filler application for therapeutic purpose.					
Additional Privileges *(Specify if any)*:					

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Note:

- You must submit along with this application all necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.
- By signing below, I acknowledge that I have read, understand, and agree to abide by DHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

a) In exercising any clinical privileges granted, I am constrained by DHP's policies and rules applicable generally and any applicable to the particular situation.
b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the recognized policies and rules.

…….. ……
Applicant's signature (Stamp if any) Date

…….. ……
Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signature Date

For Committee use only

Committee Decision:

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Evaluation type:

By Interview	☐	virtual / personal
By documents only	☐	
Or both	☐	

Other comments:

……

Evaluation Committee Chairman:

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant, and I have made the above-noted recommendation(s).

……. ……
Chairperson's Stamp & signature Date

Other Committee Members:

……. ……
1) Name Date

……. ……
2) Name Date

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