PRIVILEGES THAT NEED SPECIAL APPROVAL PRIVILEGE REQUEST

Applicant's Name: .....

License No. : .....

Scope of Practice: .....

	Privileges	For applicant use		For committee use		
		Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1	Administration of Nitrous oxide					
2	Construction / insertion of obstructive Sleep Apnea Appliances					
3	Botox and Filler					
Additional Privileges (Specify if any):						

Committee Decision:

Evaluation type:

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

Other comments:

.....

.....

Clinical privileging committee members:

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

Committee members:

Name: ..... Date: .....
Signature: ..... Stamp: .....

Name: ..... Date: .....
Signature: ..... Stamp: .....

Name: ..... Date: .....
Signature: ..... Stamp: .....

Medical director of the facility:

Name: ..... Date: .....
Signature: ..... Stamp: .....