ADVANCED NON-CORE PRIVILEGE FORM: ORAL AND MAXILLOFACIAL SURGERY 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	Orthognathic surgery including Snoring and sleep apnea correction surgery.					
2	Reconstructive surgery of the face.					
3	Congenital craniofacial 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 (no reconstruction)					
Additional Privileges (Specify if any):						

For Committee use only

Committee Decision:

Evaluation type:

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

Other comments:

.....

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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: .....