



## NON-CORE PRIVILEGE FORM: ORAL 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	Surgical exposure of un-erupted teeth					
2	Removal of impacted teeth					
3	Removal of remaining roots					
4	Removal of oral cavity cysts					
5	Transplantations of teeth					
6	Removal of foreign bodies in soft tissue and hard tissue					
7	Removal of palatal/alveolar exostoses					
8	Vestibuloplasty prosthetic surgery (e.g. alveoplasty, alveolar bone augmentation, sinus lifting etc.					
9	Closure of oroantral fistulas					
10	Intraoral hard tissue biopsy sampling					
11	Frenectomy					
12	Palatal tissue hyperplasia reduction					

Additional Privileges (Specify if any):						

**For Committee use only**

**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: .....