Non-core Privilege Form: Orofacial Pain
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.)**

Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Provide accurate diagnosis of the most common intraoral and orofacial pain conditions, be able to recognize the more complex orofacial pain conditions, and initiate referrals to appropriate experts in managing such patients.					
2. Perform extensive temporomandibular joint, masticatory, and cervical muscle examination, evaluation of dental occlusion.					
3. Diagnostic and treatment procedures including I. Craniofacial nerve blocks. II. Intramuscular trigger point injections in the masticatory, head, and neck muscles. III. Cognitive-behavioral management strategies.					
4. Pharmacotherapy management including topical and systemic analgesics, muscle relaxants, anxiolytics, anticonvulsants, antidepressants					
5. Performing some of physiotherapy modalities including Manual manipulation, Ultrasound therapy, TENS, Therapeutic exercises.					
6. Fabrication of oral occlusal appliances.					
7. Selective occlusal therapy					
8. Botox injection therapy for headaches and muscle pain conditions.					

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:

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