Non-core Privilege 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.)**

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Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
CATEGORY I: CORE PRIVILEGES					
1. Admitting privileges					
2. Admission history & physical examination					
3. Interpretation of laboratory tests					
4. Oropharyngeal airway insertion					
5. Prescribing oxygen therapy					
CATEGORY II: SPECIAL PROCEDURES (Oral and Maxillofacial Surgery)					
1. Examination, diagnosis and treatment planning for all Oral & Maxillofacial Surgery patients using x-ray, lab tests and other diagnosis procedures.					
2. Exodontia: Extraction of erupted teeth requiring removal by conventional methods					
3. Complicated Exodontias: Managing the complicated of dental extraction e.g. fractured teeth, bleeding socket, oroantral communication and fractures of the mandible and maxilla (maxillary tuberosity).					
4. Exodontia of Impacted Teeth: Surgical removal of upper and lower wisdom teeth, upper & lower canines, etc.					

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Privileges	For applicant use		For committee use		
	Request	***Signature***	***Recommended***	***Not Recommended***	***Reason for rejection (if any)***
4. Peri-Apical Surgeries: Performing apicectomies for the teeth with periapical pathologies with removal of cystic lesions from the jaws					
5. Pre-Prosthetic Surgeries: Removal of high frenal attachments, sharps bones, denture granulomas, fibrous maxillary tuberosities and maxillary and mandibular tori.					
6. Pre-Orthodontic Surgery: Removal of high frenal attachments and surgical exposure of impacted teeth.					
7. Dentoalveolar Trauma.					
8. Dental Implantology: Performing dental implants with sinus lifts and ridge augmentation procedures.					

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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

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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