Delineation of Privileges

DENTAL SERVICE

NAME ______________________________

Privileges Requested	Privileges Granted	
		REHABILITATION OF DENTAL ARCHES
______	______	Operative restorations
______	______	Crown & bridge preparation(s)
______	______	Prosthetic replacement of teeth
______	______	Implantation of teeth (proofing of training, or specialist)
		ORAL PROSTHESIS
______	______	Oral prosthesis for malformation of the face, jaws and mouth: (Specialist)
______	______	(a) Congential
______	______	(b) Pathological
______	______	(c) Traumatic
		PERIDONTAL SURGERY
______	______	Gingivectomy/Gingivoplasty
______	______	Alveloar contouring
______	______	Perio scaling/Root Planing
______	______	Alveolar Bone Grafting (Specialist)
		ENDODONTICS
______	______	Root Canal Therapy
______	______	With immediate root resection (Specialist)
______	______	Apicoectomy/Retrograde Filling (Specialist)
		ALVEOLAR SURGERY
______	______	Single uncomplicated extractions
______	______	Multiple uncomplicated extractions
______	______	Surgical removal of impacted teeth
______	______	Soft Tissue, Partial ____ Full ____
______	______	Bony Tissue, Partial ____ Full ____ (sp.)
		INTRA-ORAL SURGERY
______	______	Apicoectomy (Specialist)
______	______	Alveolectomy
______	______	Alveoloplasty
______	______	Torus palatinus, excision of
______	______	Torus mandibularis, excision of
______	______	Minor lacerations, repair of
______	______	Major extensive cysts, excision of (Specialist)
______	______	Minor infections, I & D of
______	______	Major infections, I & D of (Specialist)
______	______	Salivary gland surgery, submaxillary (Specialist)
______	______	Salivary duct surgery (Specialist)
______	______	Tongue surgery (Specialist)
______	______	Repair (Specialist)

Privileges Requested	Privileges Granted	
		Ranula, treatment of (Specialist)
		Caldwell-Luc, w/wo antrostomy (Specialist)
		Transplantation of teeth (Specialist)
		Thermal burns of mouth, care of (Prostho, Pedo, Oral Surgeon)

EXTRA-ORAL ORAL SURGERY

Privileges Requested	Privileges Granted	
		Minor infections, I & D of (Specialist)
		Major infections, I & D of (Specialist)
		Minor lacerations, repair of (Specialist)
		Major lacerations, repair of (Specialist)
		Major extensive cysts, excision of (Specialist)
		Lip Surgery (Specialist)
		(a) congential
		(b) pathological
		(c) traumatic
		Salivary gland surgery submaxillary (Specialist)
		Benign tumors, excision of (Specialist)
		Scar revision (Specialist)
		Node biopsy (Specialist)

FRACTURES OF THE JAWS & ASSOCIATED STRUCTURES

Privileges Requested	Privileges Granted	
		Maxilla, closed reduction (Specialist)
		Maxilla, open reduction (Specialist)
		Mandible, closed reduction (Specialist)
		Mandible, open reduction (Specialist)
		Zygoma, closed reduction (Specialist)
		Zygoma, open reduction (Specialist)
		Zygomatic arch, closed reduction (Specialist)
		Zygomatic arch, open reduction (Specialist)
		Trimalar fractures

OTHER EXTRA-ORAL ORAL SURGERY

Privileges Requested	Privileges Granted	
		Bone graft, maxilla, mandible, zygoma (Specialist)
		Micrognathia, maxilla/mandible, correction of (Specialist)
		Macrognathia, maxilla/mandible, correction of (Specialist)
		Insertion of extra-oral pins/appliances, including head frame (Specialist)
		Sequestractomy, osteomyelitis (Specialist)
		Foreign body, removal of (Specialist)
		Apertognathia, maxilla/mandible, correction of (Specialist)
		Genioplasty reduction/augumentation (Specialist)

TEMPORO-MANDIBULAR JOINT

Privileges Requested	Privileges Granted	
		Condylectomy and/or condylar contouring (Specialist)
		Reduction of subluxation
		Arthroplasty of, for ankylosis (Specialist)
		Meniscectomy (Specialist)
		Condylar implementation & implantation (Specialist)
		Meniscoplasty (plication) (Specialist)
		Total/Partial/Joint Reconstruction (Specialist)

SOFT TISSUE PROCEDURES

Privileges Requested	Privileges Granted	
		Sulcus deepening & ridge extension w/wo skin graft (Specialist)
		Avulsion of nerve, mental infraorbital, inf. Alveolar (Specialist)
		Treatment of trigeminal neuralgia (Specialist)
		Closure of oro-nasal/oro-antral fistula (Specialist)
		Removal of skin for graft (Specialist)

Privileges Requested	Privileges Granted	
		SPECIAL EMERGENCY PROCEDURES
______	______	Tracheotomy (Specialist)
______	______	Extra-oral ligation of vessels (Specialist)
______	______	Cut-down, venous, other parts of body (Specialist)
		OTHER
______	______	Admission History (Oral Surgeon)

______________________________ ______________

Signature of Applicant Date

Requested Privileges: Approved as Indicated ______ Denied ______

***If denied, please provide explanation on separate sheet**

______________________________ ______________

Signature of Service Chief Date

HEALTH STATEMENT

TO CHIEF OF SERVICE / CHIEF OF STAFF

1. **I HEREBY CERTIFY THAT I POSSESS THE NECESSARY COGNITIVE AND MOTOR SKILLS TO SAFELY PERFORM ALL PRIVILEGES REQUESTED AND DECLARE MYSELF TO BE FREE FROM ANY CONDITION, ILLNESS, OR INFECTIOUS DISEASE THAT COULD COMPROMISE PATIENT CARE OR MY ABILITY TO PERFORM THE PRIVILEGES REQUESTED.**

   ☐ **YES** ☐ **NO**

2. **IF NO, DO YOU HAVE A PHYSICAL OR MENTAL CONDITION OR ILLNESS (INCLUDING ANY CHEMICAL OR ALCOHOL DEPENDECY) WHICH COULD AFFECT YOUR ABILITY TO EXERCISE THE CLINICAL PRIVILEGES REQUESTED WITHOUT SPECIAL ACCOMMODATIONS IN ORDER FOR YOU TO EXERCISE THE PRIVILEGES REQUESTED SAFELY AND COMPETENTLY? TO ANSWER THIS QUESTION APPROPRIATELY, PLEASE REPORT ANY CONDITION WHICH IS, OR MAY BE INFECTIOUS, COULD AFFECT MOTOR SKILLS, COGNITIVE ABILITY OR JUDGMENT, OR COULD POTENTIALLY ADVERSELY AFFECT YOUR ABILITY TO CARE FOR PATIENTS OR TO INTERACT APPROPRIATELY WITH OTHER CAREGIVERS.**

   ☐ **YES** ☐ **NO**

   If yes, please explain:

   ____

   ____

   ____

3. **HAVE YOU TESTED POSITIVE FOR THE TUBERCULIN SKIN TEST?** ☐ **YES** ☐ **NO**
   If yes, please give date of positive skin test. ____________________________
   If no, when was your last PPD test? ________________________

   REGARDLESS OF HOW THIS QUESTION IS ANSWERED, THE APPLICATION WILL BE PROCESSED IN THE USUAL AND CUSTOMARY MANNER. IF YOU HAVE ANSWERED THIS QUESTION AFFIRMATIVELY AND ARE FOUND TO BE PROFESSIONALLY QUALIFIED FOR MEDICAL STAFF APPOINTMENT AND CLINICALLY COMPETENT TO PERFORM THE CLINICAL PRIVILEGES REQUESTED, YOU WILL BE GIVEN AN OPPORTUNITY TO MEET WITH THE EXECUTIVE COMMITTEE TO DETERMINE WHAT ACCOMMODATIONS, IF ANY, ARE NECESSARY TO ALLOW YOU TO PRACTICE SAFELY.

______________________________ ____________________
SIGNATURE OF APPLICANT **DATE**

______________________________ ____________________
CHIEF OF SERVICE **DATE**