



**CORE PRIVILEGES  
OTOLARYNGOLOGY**

**QUALIFICATIONS:**

- MD or DO with successful completion of an ACGME or AOA-accredited residency training program in otolaryngology and acceptable practice experience in the privileges requested;
- Current certification or active participation in the examination process leading to certification in otolaryngology by the American Board of Otolaryngology or equivalent certification as determined by the Service Chief;
- Documentation or attestation of the performance of at least 100 otolaryngology surgical procedures during the past two (2) years. *Reappointments: please be prepared to provide a list of cases performed at facilities other than Teche Regional Medical Center if requested.*

(R)= Recommended as Requested (A)=Approved as Requested (C)=Recommended with Condition(s) (N)=Not Recommended

Requested						
Yes	No	<b>CORE PRIVILEGES:</b>	(R)	(A)	(N)	(C) Condition/Reason(s)
		<p>Core privileges in otolaryngology (ENT) shall include the admission, consultation, and the medical and surgical evaluation in/or treatment to patients of all ages presenting with illnesses, injuries, and disorders of the head and neck, ears, facial skeleton, upper respiratory tract and upper alimentary system.</p> <p>Privileges include, but are not limited to surgery of the middle ear, tympanomastoidectomy, mastoidectomy, surgery of the nose and sinuses, facial fracture repair, radical neck dissection, major salivary gland surgery, thyroidectomy, laryngectomy, and glossectomy. Plastic and reconstructive surgery includes laceration repair. Other interventional procedures include bronchoscopy, esophogoscopy, laryngoscopy, major reconstructive surgery of the head and neck.</p> <p><i>[You may mark through any privilege you will not be doing at this facility and do not wish to request]</i></p>				
		<b>SPECIAL PRIVILEGES:</b>				
		[Documentation of formal training, and/or additional course work is required in the absence of evidence of current practice experience and utilization. Proctoring may be imposed at the discretion of the Service Chief]				
		Acoustic neuroma				
		Liposuction of the head and neck areas				
		Blepharoplasty and face lifts				
		Open/closed reduction of major mandibular fractures				
		Use of Lasers (if equipment becomes available) - requires review and adherence to MWH Standards for the safe use of CO2, surgical Nd YAG, Argon, KTP and Tuneable dye lasers, documented laser training during a residency program OR successful completion in an educational program concerning laser physics, indication, equipment use and complications, with 2 proctored or observed cases.				Note: Equipment currently not available.

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Teche Regional Medical Center. I also attest to meeting the minimum qualifications having performed at least 100 ENT procedures in the past 24-months.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**Requested clinical privileges reviewed and recommend as indicated above.**

\_\_\_\_\_  
Signature of Service or Department Chair

\_\_\_\_\_  
Date

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**Board of Trustees' Decision**

*Teche Regional Medical Center's Board of Trustees*

**Does**

**Does not grant clinical privileges as requested**

(if "does not" grant, give reasons in letter to the applicant with a copy of privilege list)

\_\_\_\_\_  
Secretary, Board of Trustees

\_\_\_\_\_  
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 DEPENDENCY) 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:

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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