CARLSBAD MEDICAL CENTER

OTOLARYNGOLOGY
APPLICATION FOR PRIVILEGES

NAME OF APPLICANT: ______________________________

BOARD CERTIFICATION: ______________________ DATE: ______________

Privileges in Otolaryngology are granted for both clinical cognitive areas and specific procedures. All practitioners requesting Otolaryngology privileges are to be board certified by the American Board of Otolaryngology or by the American Osteopathic Board of Otolaryngology, or must be fully trained in an accredited residency program recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

CHECK EACH AREA FOR WHICH YOU ARE REQUESTING PRIVILEGES:

R = Requested G = Granted D = Denied

GENERAL COGNITIVE PRIVILEGES

[ ] [ ] [ ] Admitting and Attending Privileges
[ ] [ ] [ ] Assisting in Surgery Only
[ ] [ ] [ ] Consultation Only
[ ] [ ] [ ] Critical Care Admission and Management

PRIVILEGE LEVEL	PROCEDURAL PRIVILEGES
Level 1	USUAL AND CUSTOMARY OTOLARYNGOLOGY PROCEDURAL PRIVILEGES: 1) These procedural privileges are usually and customarily performed by board certified or fully trained Otolaryngologist ; and 2) Documentation of specific training and/or experience in Level 1 procedural privileges may be required; and 3) Level 1 procedural privileges are unasterisked.

PRIVILEGE LEVEL	PROCEDURAL PRIVILEGES
Level 2	ADVANCED OTOLARYNGOLOGY PROCEDURAL PRIVILEGES 1) These procedural privileges may be performed by board certified or fully trained Otolaryngologist; and 2) Level 2 procedural privileges require documentation of training and experience; and 3) Individual Level 2 procedural privileges must be proctored as defined on this privilege delineation form; and 4) Level 2 procedural privileges are denoted by * (one asterisk).

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NOTE: If applying for an asterisked (*) privilege, enter the number and location of procedures performed in the last 2 years.

R	G	D		# Performed	Location Performed
SURGICAL PROCEDURES					
ANESTHESIA PROCEDURES					
			CONSCIOUS SEDATION		
[ ]	[ ]	[ ]	Pediatric (<15 years) Moderate Sedation*	____	____________
[ ]	[ ]	[ ]	Adult Moderate Sedation*	____	____________
[ ]	[ ]	[ ]	Pediatric (<15 years) Deep Sedation*	____	____________
[ ]	[ ]	[ ]	Adult Deep Sedation*	____	____________
ENDOSCOPIC PROCEDURES					
[ ]	[ ]	[ ]	Bronchoscopy		
[ ]	[ ]	[ ]	With Biopsy		
[ ]	[ ]	[ ]	With foreign body removal		
[ ]	[ ]	[ ]	Dilation of Stricture		
[ ]	[ ]	[ ]	Bronchoscopy, Flexible		
[ ]	[ ]	[ ]	Adult		
[ ]	[ ]	[ ]	Child		
[ ]	[ ]	[ ]	Bronchoscopy Rigid		
[ ]	[ ]	[ ]	Adult		
[ ]	[ ]	[ ]	Child		
[ ]	[ ]	[ ]	Esophagoscopy		
[ ]	[ ]	[ ]	With Biopsy		
[ ]	[ ]	[ ]	With Foreign Body Removal		
[ ]	[ ]	[ ]	Dilation of Stricture		
[ ]	[ ]	[ ]	Laryngoscopy		
[ ]	[ ]	[ ]	Flexible		
[ ]	[ ]	[ ]	Rigid		
[ ]	[ ]	[ ]	With Biopsy		
[ ]	[ ]	[ ]	With Foreign Body Removal		
[ ]	[ ]	[ ]	With Teflon Injection of Vocal Cords		
[ ]	[ ]	[ ]	Nasal and Sinus Endoscopy		
[ ]	[ ]	[ ]	Diagnostic		
[ ]	[ ]	[ ]	Surgery		
NOSE AND MAXILLA AND SINUSES					
[ ]	[ ]	[ ]	Antrostomy		
[ ]	[ ]	[ ]	Caldwell Luc Procedure		
[ ]	[ ]	[ ]	Excision of Nasopharyngeal tumors		
			Ethmoidectomy		
[ ]	[ ]	[ ]	Frontoethmoidectomy		
[ ]	[ ]	[ ]	Intranasal		
[ ]	[ ]	[ ]	External		
[ ]	[ ]	[ ]	Frontal Sinus Ablation		
[ ]	[ ]	[ ]	Lateral Rhinotomy		
[ ]	[ ]	[ ]	Maxillectomy, Partial		
[ ]	[ ]	[ ]	Nasal Polypectomy		
[ ]	[ ]	[ ]	Osteoplastic Frontal Sinusectomy		
[ ]	[ ]	[ ]	Pterygomaxillary Fossa Exploration		
[ ]	[ ]	[ ]	Radical Pansinusectomy		
[ ]	[ ]	[ ]	Repair of Choanal atresia		
[ ]	[ ]	[ ]	Septal Dermatoplasty/Reconstruction		
[ ]	[ ]	[ ]	Septoplasty		
[ ]	[ ]	[ ]	Transantral ligation of vessels		
[ ]	[ ]	[ ]	Turbinectomy		

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R	G	D		# Performed	Location Performed
HEAD AND NECK PROCEDURES					
[ ]	[ ]	[ ]	Abbe-Estander Flap Procedure		
[ ]	[ ]	[ ]	Adenoidectomy		
[ ]	[ ]	[ ]	Arytenoidectomy		
[ ]	[ ]	[ ]	Arytenoidopexy		
[ ]	[ ]	[ ]	Esophagoectomy, cervical with/without radical neck dissection*	______	______
[ ]	[ ]	[ ]	Cricothyroidotomy		
[ ]	[ ]	[ ]	Diverticulectomy		
[ ]	[ ]	[ ]	Epiglottidectomy		
			Excision:		
[ ]	[ ]	[ ]	Auricle and Neck Dissection		
[ ]	[ ]	[ ]	Benign Lesions and Lymph Nodes		
[ ]	[ ]	[ ]	Congenital Cysts		
[ ]	[ ]	[ ]	Laryngocele		
[ ]	[ ]	[ ]	Tumors		
[ ]	[ ]	[ ]	Glossoplasty		
			Laryngectomy*	______	______
[ ]	[ ]	[ ]	Subtotal		
[ ]	[ ]	[ ]	Wide Field		
[ ]	[ ]	[ ]	With Radical Neck Dissection		
[ ]	[ ]	[ ]	Ligation of External Carotid Artery		
[ ]	[ ]	[ ]	Mediatinoscopy		
[ ]	[ ]	[ ]	Parathyroidectomy*	______	______
[ ]	[ ]	[ ]	Pharyngostomy		
[ ]	[ ]	[ ]	Repair of Laryngotracheal Injuries*	______	______
[ ]	[ ]	[ ]	Surgical Treatment of Laryngeal Fissures		
[ ]	[ ]	[ ]	Thyroidectomy*	______	______
[ ]	[ ]	[ ]	Tongue Advancement		
[ ]	[ ]	[ ]	Tonsillectomy		
[ ]	[ ]	[ ]	Tracheostomy		
[ ]	[ ]	[ ]	Wedge Resection of Lesion		
ORAL CAVITY AND SALIVARY GLANDS					
			Excision of		
[ ]	[ ]	[ ]	Ranula		
[ ]	[ ]	[ ]	Tori Palatine and Mandibularis		
[ ]	[ ]	[ ]	Submandibular Gland		
[ ]	[ ]	[ ]	Canaloplasty		
[ ]	[ ]	[ ]	Frenulectomy		
[ ]	[ ]	[ ]	Siololithotomy		
[ ]	[ ]	[ ]	Sialodochoplasty		

CARLSBAD MEDICAL CENTER –REQUEST FOR PRIVILEGES

Name of Applicant: ______________________________

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NOTE: If applying for an asterisked (*) privilege, enter the number and location of procedures performed in the last 2 years.

R	G	D		# Performed	Location Performed
OTOLOGIC					
[ ]	[ ]	[ ]	Exploratory Tympanotomy		
[ ]	[ ]	[ ]	Facial Nerve Decompression		
			Mastoidectomy		
[ ]	[ ]	[ ]	Simple		
[ ]	[ ]	[ ]	Radical		
[ ]	[ ]	[ ]	Tympano		
			Myringotomy		
[ ]	[ ]	[ ]	Without insertion of PE Tubes		
[ ]	[ ]	[ ]	With insertion of PE Tubes		
[ ]	[ ]	[ ]	Ossicular Reconstruction		
[ ]	[ ]	[ ]	Sinus Ablation		
[ ]	[ ]	[ ]	Stapedectomy/Stapedotomy/Mobilization*	______	______________
[ ]	[ ]	[ ]	Tympanic Neurectomy		
[ ]	[ ]	[ ]	Tympanomastoid Reconstruction		
[ ]	[ ]	[ ]	Tympanoplasty/Myringoplasty		
FACIAL COSMETIC AND RECONSTRUCTIVE SURGERY					
[ ]	[ ]	[ ]	Bleparoplasty		
[ ]	[ ]	[ ]	Bone Graft		
[ ]	[ ]	[ ]	Browplasty/Lift		
[ ]	[ ]	[ ]	Cartilege		
[ ]	[ ]	[ ]	Cheiloplasty		
[ ]	[ ]	[ ]	Cleft Lip and Palate Repair*	______	______________
[ ]	[ ]	[ ]	Composit Graft		
[ ]	[ ]	[ ]	Cranioplasty*	______	______________
[ ]	[ ]	[ ]	Excision of Cutaneous Lesions		
[ ]	[ ]	[ ]	Facial Liposuction		
[ ]	[ ]	[ ]	Facial Nerve Reanimation		
[ ]	[ ]	[ ]	Forehead Lift*	______	______________
[ ]	[ ]	[ ]	Lateral Canthoplasty		
[ ]	[ ]	[ ]	Mandibular Reconstruction		
[ ]	[ ]	[ ]	Mental Augmentation		
[ ]	[ ]	[ ]	Mentoplasty		
[ ]	[ ]	[ ]	Oral Antral Fistula Repair		
[ ]	[ ]	[ ]	Otoplasty		
[ ]	[ ]	[ ]	Palatoplasty		
[ ]	[ ]	[ ]	Pedicle Flap Reconstruction		
[ ]	[ ]	[ ]	Reconstruction of External Ear		
			Reduction of Facial Fracture		
[ ]	[ ]	[ ]	Alveolar		
[ ]	[ ]	[ ]	Frontal		
[ ]	[ ]	[ ]	Mandibular		
[ ]	[ ]	[ ]	Midface (LaForte I, II, III)		
[ ]	[ ]	[ ]	Nasal Facial		
[ ]	[ ]	[ ]	Orbital "Blowout"		
[ ]	[ ]	[ ]	Zygomatic		
[ ]	[ ]	[ ]	Rhinoplasty		
[ ]	[ ]	[ ]	Rhytidectomy*	______	______________
[ ]	[ ]	[ ]	Scar Revision		
[ ]	[ ]	[ ]	Musculocutaneous Flap Reconstruction*	______	______________

Name of Applicant: ____________________

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NOTE: If applying for an asterisked (*) privilege, enter the number and location of procedures performed in the last 2 years.

R	G	D		# Performed	Location Performed
			Facial Cosmetic and Reconstructive Surgery—Continued		
			Skin Graft Application		
[ ]	[ ]	[ ]	Split Thickness		
[ ]	[ ]	[ ]	Full Thickness		
[ ]	[ ]	[ ]	Tracheoplasty		
			OTHER PROCEDURES		
[ ]	[ ]	[ ]	Specify: ____________	______	____________
[ ]	[ ]	[ ]	Specify: ____________	______	____________

I certify that I have had the necessary training and experience to perform the procedures that I have requested.

NAME OF APPLICANT (Please Print) SIGNATURE DATE

APPROVALS

All privilege delineations have been individually considered and have been recommended based upon the practitioner's specialty, licensure, specific training, experience, health status, current competence and peer recommendations.

APPLICANT MAY PERFORM PRIVILEGES AND PROCEDURES AS INDICATED:

EXCEPTIONS/LIMITATIONS:

(specify)

Surgery Department Chairperson Date

Medical Staff Executive Committee Date

Board of Trustees Date

Name of Applicant: ______________________________

OTOLARYNGOLOGY

REQUEST FOR CLINICAL PRIVILEGES

Privileges followed by an asterisk (*) are identified in this table. Please submit required documentation when applicable at the time of appointment or reappointment. The numbers indicated in this table represent the minimal number of documented procedures required to be submitted for consideration of the advanced privilege requested. Additional documentation of training, experience and/or current competence may be requested and additional proctoring may be requested at any time by the Department Chairperson, or the Medical Executive Committee for any privilege requested.

PROCEDURES	TRAINING/EXPERIENCE	Number of Documented Procedures for Initial Appointment	Number of Procedures Every 2 Years	Number of Procedures to be Initially Proctored
ANESTHESIA				
Conscious Sedation – Pediatric (<15 years) Moderate Sedation or Analgesia	See Attachment C	2	1	N/A
Conscious Sedation – Adult Moderate Sedation or Analgesia	See Attachment C	2	1	N/A
Conscious Sedation – Pediatric (<15 years) Deep Sedation or Analgesia	See Attachment C	2	1	4
Conscious Sedation – Adult Deep Sedation or analgesia	See Attachment C	2	1	4
HEAD AND NECK PROCEDURES				
Esophagoectomy, cervical with/without radical neck dissection	Documentation of Successful Performance	6	2	2
Laryngectomy	Documentation of Successful Performance	6	2	2
Paratheroidectomy	Documentation of Successful Performance	6	2	2
Repair of Laryngotracheal Injuries	Documentation of Successful Performance	6	2	2
Thyroidectomy	Documentation of Successful Performance	6	2	2
OTOLOGIC				
Stapedectomy/ Stapedotomy/Mobilization	Documentation of Successful Performance	6	2	2
FACIAL COSMETIC AND RECONSTRUCTIVE SURGERY				
Cleft Lip and Palate Repair	Documentation of Successful Performance	2	1	1
Cranioplasty		2	1	1
Forehead Lift		2	1	1
Rhytidectomy		2	1	1
Musculocutanous Flap Reconstruction		2	1	1

MEDICAL STAFF CREDENTIALING CRITERIA FOR CONSCIOUS SEDATION

Moderate Sedation or Analgesia
Separate privileges are granted for the categories of adult and pediatric (< 15 years) moderate sedation or analgesia, based on documentation of current competency.

All medical staff requesting any conscious sedation privilege must complete and document a review of the current medical staff conscious sedation policy. In addition to the required review of the conscious sedation policy, practitioners requesting privileges in conscious sedation must meet requirements of either #1**or** #2 listed below:

1. Documentation of training, experience and current competence related to the use of moderate sedation or analgesia, **and** successful performance of at least (1) moderate sedation/analgesia case in the last (2) years for each category of moderate sedation or analgesia applied for and (2) sedation/analgesia cases at initial appointment **OR**
2. Documentation of relevant training and experience **AND**
   a. Attendance at a Carlsbad Medical Center sponsored CME program on moderate sedation/analgesia **or** review of the videotape of such conference **and** achievement of a score of 85% or higher on the moderate sedation/analgesia post-test, **AND** provisional privileges will be granted pending outcome review.

Deep Sedation or Analgesia

Separate privileges to be granted for the categories of adult and pediatric (< 15 years) deep sedation or analgesia based on documentation of current competency. **All** medical staff requesting any conscious sedation privilege, must complete and document a review of the current medical staff conscious sedation policy AND maintain current ACLS certification (*PALS or NALS as appropriate*); **OR** be Board Certified or fully trained in a Carlsbad Medical Center approved residency training program in Emergency Medicine, Anesthesiology or Critical Care Medicine.

In addition to the required review of the conscious sedation policy, ACLS and board certification or residency requirements above, practitioners requesting privileges in conscious sedation must meet requirements of either #1 **or** #2 listed below:

1. Documentation of training, experience and current competence related to use of deep sedation/analgesia, **and** successful performance of at least (1) deep sedation/analgesia cases in the last (2) years for each category of deep sedation or analgesia applied for **OR**
2. Documentation of relevant training and experience, **AND ALL** of the following:
   a. Attendance at a Carlsbad Medical Center-sponsored CME program on deep sedation/analgesia or review of the videotape of such conference and achievement of the score of 85% or higher on the deep sedation/analgesia post-test, **AND**
   b. Provide documentation of successful completion of four (4) deep sedation/analgesia cases, in each category applied for, under the direct supervision of a Carlsbad Medical Center practitioner holding appropriate clinical privileges in deep sedation. If applying for both categories of deep sedation/analgesia, a total of six (6) cases will satisfy this requirement **AND**
   c. Successful completion of four (4) intubations in the Operating Room under the direct supervision of a Carlsbad Medical Center credentialed anesthesiologist. If applying for both categories of deep sedation/analgesia, a total of six (6) cases will satisfy this requirement.

AUTHORIZATION FOR BACKGROUND CHECK

By signing below, I grant permission to the Hospital, its medical staff and representatives ("Hospital") to obtain an investigative report, to include state and federal criminal records and driving arrest records, for purposes of processing my medical staff application. I understand that I may request the Hospital to disclose the nature and scope of the investigation requested within five (5) days of my written request made within a reasonable time after the Hospital obtains the information. I also understand that I am entitled to request a summary of my rights with respect to consumer reporting agencies.

____
Print Name

____
Signature

____
Date