

CLINICAL PRIVILEGES IN OTOLARYNGOLOGY

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Initial

Renewed

Name _____ Effective from ___ / ___ / ___ to ___ / ___ / ___

Applicant: Please initial in the box in the R column for each privilege requested.

R = Requested G = Recommended As Requested C = Recommended with Conditions N = Not Recommended

Note: If Recommendations for clinical privileges are conditional, modified or are not recommended, the specific condition and its reason must be stated where indicated on the last page of this form.

R G C N Salivary Gland

- Myringoplasty
Myringotomy
Ossicular Reconstruction
Otoscopy
Removal of Tubes
Submaxillary Gland Excision
Tympanoplasty
Tympanotomy

R G C N Nose and Maxilla

- Antral Window-Intranasal Antrostomy
Biopsy: Transantral
Biopsy: Transethmoid
Biopsy: Transpalatal
Endoscopy Sinus
Lateral Rhinotomy
Nasal Cautery
Nasal Fracture Open Reduction
Nasal Fracture Closed Reduction
Septorhinoplasty

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R G C N Nose and Maxilla Continued

Other (Please specify):

R G C N Lips

Lip Shave
 Wedge Resection

R G C N Neck

Cervical Node Biopsy
 Excision of Benign Lesions
 I & D Abscess
 Scalene Node Biopsy

R G C N Laryngectomy

Bronchiogenic Cysts
 Congenital Cysts
 Dermoids
 Thyroglossal Cysts

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R G C N Otolologic

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cochlear Implant |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endolymphatic Shunt |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Middle Ear Exploration |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Myringoplasty |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paper Patch Ear Drum |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Radical Mastoidectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Simple Mastoidectomy |

R G C N Otolologic

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stapedectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Surgical Sinus Ablation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tympanoplasty |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Simple Mastoidectomy |

R G C N Plastic and Reconstructive

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blepharoplasty |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excision of Skin Lesions |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Grafts: Full Thickness Skin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Grafts: Split Thickness Skin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Implants |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reduction of Facial Fractures: Closed / Open |

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R G C N Plastic and Reconstructive Continued

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reduction of Facial Fractures: Nasal |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rhinoplasty |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rhytidectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Scar Revision |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | TMJ Exploration |

R G C N General Otolaryngology Privileges

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adjunctive Care |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adenoidectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Caldwell Luc |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frenulectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frontal Sinusotomy (Trepine) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemangioma Eye |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intranasal Ethmoidectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intranasal Polypectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nasal Polypectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Labyrinthectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laceration Repair |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ligation of Vessel |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Oval/Round Window Fistula Repair |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sialothotomy Excise Salivary Stone |

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R G C N General Otolaryngology Continued

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | T & A |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tongue Biopsy/Lesion Excision |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tracheotomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | True Vocal Cord Injection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Turbineotomy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Uvulopalatoplasty (UPPP) |

R G C N Other

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laser: CO2 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laser: KTP |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | X-Ray Interpretation: C-Arm |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | X-Ray Interpretation: Fluroscan |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | X-Ray Interpretation: Portable X-Ray |

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I have requested only those specific privileges for which my education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at *SSM St. Clare Surgical Center*. I request privileges for the above procedure(s) with the understanding that I consider myself to be in good physical and mental health and I am capable of providing quality care that is acceptable to *SSM St. Clare Surgical Center*.

I verify/confirm that I have am currently privileged to perform the same procedures that I am requesting, above, at a local, Joint Commission Accredited, State licensed, and Medicare approved hospital.

Practitioner Signature Practitioner Name: Type or Print Date

Approved by the Credential/Medical Advisory Committee of the Medical Staff and duly appointed to the Medical Staff by the Governing Board.

Medical Director Approval Date

Governing Board Date

If Recommendations for clinical privileges are conditional, modified or are not recommended, the specific condition and reason(s) must be stated on this last page and practitioner notified in writing within three days by Administrator and Medical Director.