Huntington Hospital

Delineation Of Privileges

Oral /Maxillofacial Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

ORAL/MAXILLOFACIAL SURGERY PRIVILEGES

Criteria: Board Certification or qualified for certification by the American Board of Oral and Maxillofacial Surgery.
Proctoring Requirements: A minimum of six (6) cases in accordance with the Medical Staff Proctoring Protocol.

GENERAL PRIVILEGES:

Admit patients	___	___	___
Consultation Only Privileges	___	___	___
Surgical Assist ONLY	___	___	___
Sedation analgesia ***Criteria***: Requires successful completion of the Sedation Assessment Test. ***Additional criteria effective April 1, 2015:*** a) Evidence of current ACLS and/or PALS certification from the American Heart Association; AND b) Evidence of completion of an Airway Management Course	___	___	___
a) Adult Sedation	___	___	___
b) Pediatric Sedation (17 years and under)	___	___	___
CATEGORY 1 - ORAL/MAXILLOFACIAL PRIVILEGES Includes the management and coordination of care, treatment and services, including: medical history and physical examinations, consultations, and prescribing medication in accordance with DEA certificate.	___	___	___
BASIC ORAL SURGERY:			
Odontectomy	___	___	___
Alveoplasty/alveolectomy	___	___	___
Removal of maxillary and/or mandibular tori	___	___	___
Apical surgery	___	___	___
Closure of Oro-antral fistulae	___	___	___

Huntington Hospital

Delineation Of Privileges

Oral /Maxillofacial Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
PATHOLOGY			
Intra-oral biopsy	___	___	___
Extra-oral biopsy	___	___	___
Intra-oral removal of benign cysts and tumors	___	___	___
Extra-oral removal of benign cysts and tumors	___	___	___
Intra-oral removal of malignant cysts and tumors	___	___	___
Extra-oral removal of malignant cysts and tumors	___	___	___
Removal of foreign bodies/hardware	___	___	___
Salivary gland surgery	___	___	___
Maxillary sinus surgery	___	___	___
OROFACIAL INFECTIONS:			
Incision, drainage, and management - intra-oral	___	___	___
Incision, drainage and management - extra-oral	___	___	___
Emergency Tracheostomy	___	___	___
PRE-PROSTHETIC SURGERY:			
Placement of endosseous implants	___	___	___
Placement of transosseous implants	___	___	___
Placement of subperiosteal implants	___	___	___
Alloplastic grafting	___	___	___
Autogenous bone harvest and grafting	___	___	___

Huntington Hospital

Delineation Of Privileges

Oral /Maxillofacial Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Split thickness skin harvest and grafting	___	___	___
Vestibuloplasty	___	___	___
MAXILLOFACIAL TRAUMA:			
Reduction of facial fracture:	___	___	___
a) Mandible	___	___	___
b) Maxilla	___	___	___
c) Zygoma	___	___	___
d) Nasal	___	___	___
e) Orbit	___	___	___
f) Dentoalveolar	___	___	___
Dental re-implantation/stabilization	___	___	___
Repair/revision of lacerations, intra-oral	___	___	___
Repair/revision of lacerations, extra-oral/facial/scalp	___	___	___
GRAFT PROCEDURES:			
Harvest of skin grafts for maxillofacial defect/repair/reconstruction	___	___	___
Harvest of bone or cartilage for maxillofacial repair/reconstruction	___	___	___
Alloplastic grafts for maxillofacial defect repair/reconstruction	___	___	___
ORTHOGNATHIC/RECONSTRUCTIVE SURGERY:			
Maxillary/midface procedures	___	___	___
Mandibular procedures	___	___	___

Huntington Hospital

Delineation Of Privileges

Oral /Maxillofacial Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
Genioplasty	___	___	___
Facial implant procedures	___	___	___
Closure of oro-nasal fistulae	___	___	___
Closure of alveolar clefts	___	___	___
Palatoplasty	___	___	___
Glossoplasty/glossectomy	___	___	___
TEMPOROMANDIBULAR JOINT SURGERY			
Arthrotomy and repairative procedures	___	___	___
Arthroscopy and repairative procedures	___	___	___
Total joint reconstruction	___	___	___
LASER SURGERY:			
a) C02	___	___	___
b) nd:YAG	___	___	___
c) KTP	___	___	___
d) Argon	___	___	___
e) Tunable Dye	___	___	___
f) Diode	___	___	___

Huntington Hospital

Delineation Of Privileges

Oral /Maxillofacial Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

CATEGORY 2 - ORAL/MAXILLOFACIAL SURGERY PRIVILEGES:

Criteria - New Members - Board Certification or qualified for certification by the American Board of Oral and Maxillofacial Surgery.
Criteria - Current Staff Members only: Successful completion of an approved training program; OR demonstrated acceptable practice in the privileges being requested.
Proctoring Requirements: Of the six (6) required proctoring cases, three (3) must be from the supplemental privileges section, if supplemental privileges are requested.
Competency Requirements: As outlined under each Category 2 privilege group.

CATEGORY 2 - ORAL/MAXILLOFACIAL SURGERY PRIVILEGES:

COSMETIC FACIAL SURGERY:	___	___	___
Blepharoplasty	___	___	___
Forehead lift	___	___	___
Rhinoplasty/Septorhinoplasty	___	___	___
Rhytidectomy	___	___	___
Cosmetic skin resurfacing	___	___	___
Hair transplantation	___	___	___
Otoplasty	___	___	___
Cervicofacial liposuction/lipectomy	___	___	___
Dermabrasion	___	___	___
Chemical peel	___	___	___
Endoscopically assisted procedures	___	___	___

Huntington Hospital

Delineation Of Privileges

Oral /Maxillofacial Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved
MICROSURGERY: ***Competency Requirement***: Evidence of performing at least two (2) procedures every two years, as the primary surgeon, in any of the two listed procedures below.	___	___	___
Microneural grafts	___	___	___
Microvascular grafts	___	___	___
CLEFT LIP/PALATE REPAIR: ***Competency Requirement***: Evidence of performing at least two (2) procedures every two years, as the primary surgeon, in any of the two listed procedures below.	___	___	___
Cleft lip repair/revision	___	___	___
Cleft palate repair/revision	___	___	___

ACKNOWLEDGEMENT OF THE PRACTITIONER:

I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at Huntington Hospital, and I understand that: a) in exercising my clinical privileges granted, I am constrained by hospital and medical staff 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 a situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature of Applicant: _____ Date:_____

DEPARTMENT CHAIR RECOMMENDATIONS

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Applicant may perform privileges and procedures as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

Huntington Hospital

Delineation Of Privileges

Oral /Maxillofacial Surgery Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

APPROVALS:

Section Chair: _____ Date: _____

Department Chair: _____ Date: _____

Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____