Applicant's Name

_____

OTOLARYNGOLOGY SURGERY

I hereby request surgical privileges in the specialty of Otolaryngology as shown in this form. I understand that privileges granted are subject to a bi-annual review coinciding with reapplication for medical staff membership. I also understand that application for additional or new procedures can be made at any time with proper documentation.

Please indicate with an "X" in the appropriate box and by signature at the end of this document the procedures you are requesting privileges for.

Applied for	**APPROVED**	**DENIED**
❑ Antral lavage	❑ YES	❑ NO
❑ Biopsy of nose or thynophoma	❑ YES	❑ NO
❑ Biopsy of tongue	❑ YES	❑ NO
❑ Biopsy of ear	❑ YES	❑ NO
❑ Blepharoplasty	❑ YES	❑ NO
❑ Bronchoscopy (diagnostic)	❑ YES	❑ NO
❑ Brow lift, conventional or endoscopic	❑ YES	❑ NO
❑ Caldwell-Luc procedure	❑ YES	❑ NO
❑ Dilation of esophagus	❑ YES	❑ NO
❑ Ear piercing	❑ YES	❑ NO
❑ Esophagoscopy, diagnostic or therapeutic	❑ YES	❑ NO
❑ Ethmoidectomy	❑ YES	❑ NO
❑ Evacuation hematoma of nose or septum	❑ YES	❑ NO
❑ Excision of cancer of skin	❑ YES	❑ NO
❑ Excision +/- biopsy of head and neck tumor	❑ YES	❑ NO
❑ Facial nerve reanastomosis and/or graft	❑ YES	❑ NO
❑ Facial resurfacing	❑ YES	❑ NO
❑ Fat transfer	❑ YES	❑ NO
❑ Frontal sinustrephine, drainage or surgery	❑ YES	❑ NO
❑ Genioplasty	❑ YES	❑ NO
❑ I&D of superficial abcessess	❑ YES	❑ NO
❑ Laryngoscopy, diagnostic or therapeutic, including removal of foreign body	❑ YES	❑ NO
❑ Laser assisted procedure: CO2, KTP, YAGM Q-Switch, Versapulse/pulsed dye, Eerbium	❑ YES	❑ NO
❑ Lingual tonsillectomy	❑ YES	❑ NO
❑ Mastoidectomy	❑ YES	❑ NO

❑ Maxillofacial injuries, reduction & fixation	❑ YES	❑ NO
❑ Microscopic laryngoscopy	❑ YES	❑ NO
❑ Myringotomy with/without placement of tubes	❑ YES	❑ NO
❑ Nasal septum/Submucous resection and/or septoplasty	❑ YES	❑ NO
❑ Otoplasty	❑ YES	❑ NO
❑ Pharyngoplasty	❑ YES	❑ NO
❑ Plastic repair of head & neck laceration, scars, lesions or tumors	❑ YES	❑ NO
❑ Reconstruction of external auditory canal	❑ YES	❑ NO
❑ Reconstruction of soft tissues of face, head and neck	❑ YES	❑ NO
❑ Removal of head & neck foreign bodies	❑ YES	❑ NO
❑ Rhinoplasty	❑ YES	❑ NO
❑ Rhytidectomy (all areas)	❑ YES	❑ NO
❑ Rhytidoplasty	❑ YES	❑ NO
❑ Salivary gland surgery (all types)	❑ YES	❑ NO
❑ Skin grafting (small are- 1” diameter or less)	❑ YES	❑ NO
❑ Sinus endoscopic surgery	❑ YES	❑ NO
❑ Sinus surgery	❑ YES	❑ NO
❑ Suction assisted lipectomy (all areas)	❑ YES	❑ NO
❑ Suction assisted lipectomy, head & neck areas	❑ YES	❑ NO
❑ Tonsillectomy and/or Adenoidectomy	❑ YES	❑ NO
❑ Tracheostomy	❑ YES	❑ NO
❑ Transnasal antrostomy	❑ YES	❑ NO
❑ Turbinate surgery – conventional or laser	❑ YES	❑ NO
❑ Tympanoplasty	❑ YES	❑ NO
❑ Tympanotomy with explorations of middle ear	❑ YES	❑ NO
❑ Uvulopalatopharyngoplasty (UPPP)	❑ YES	❑ NO
❑ **Radiography Use of Modality & interpretation of images (therapeutic and diagnostic)**	❑ YES	❑ NO
❑ **Ultrasound Use of Modality & interpretation of images (therapeutic and diagnostic)**	❑ YES	❑ NO
❑ **Fluoroscopy Use of Modality with State License & interpretation of images (therapeutic and diagnostic**)	❑ YES	❑ NO
❑ **Local anesthesia**	❑ YES	❑ NO
❑ **Conscious Sedation**	❑ YES	❑ NO
❑ **Supervision of Conscious Sedation Trained Registered Nurse**	❑ YES	❑ NO

❑ OTHERS NOT LISTED	❑	❑
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

Signature of Applicant _____ Date _____

Signature of QI committee chairperson _____ Date recommended _____

Signature of Governing Body chairperson _____ Date recommended _____