Providence Hospital
of North Houston

Providence Hospital of North Houston
16750 Red Oak Drive
Houston, Texas 77090

_____ _____
Print Name Date

Privilege Request Form – Oral & Maxillofacial Surgery

SECTION I – GENERAL REQUIREMENTS ORAL & MAXILLOFACIAL SURGERY

Requested Staff Category

_____ Active _____ Courtesy _____ Consulting

Basic Education: DDS OR DMD

INITIAL APPOINTMENT

Minimal formal training and experience:

- Successful completion of an American Dental Association accredited residency in oral and maxillofacial surgery that includes training for procedures of the soft and hard tissues. Those physicians without such training must demonstrate competence by poof of other training that includes both didactic and hands-on instruction that is satisfactory to the Medical Director and the Chief of the Medical Staff.
- The number of cases performed in the last 12 months for each procedure requested along with the documentation of proficiency must be sufficient to validate competence. An applicant who has just completed a residency shall provide his/her residency log. Additional documentation and monitoring may be required at the discretion of the Medical Director of the Chief of Staff. Additional documentation and monitoring may be required at the discretion of the Medical Director of the Chief of Staff. Some procedures may require additional documentation of training and experience which is acceptable to the Medical Director such as Proctoring Reports, Operative Reports and Discharge Summaries for other institutions, written communication of documents from the Chairperson of the designee of an approved academic training program, approved continuing medical education course, or clinical department from another institution attesting to completion of a specified course of training, and/or the number of the specified successful procedures performed, and/or the applicants known ability to perform a specific procedure for which the applicant has previously been formally trained to carry out in an approved program.

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- Member in good standing of an accredited acute care hospital and/or ambulatory surgery center, with the same or similar unrestricted privileges.
- Interview by the Medical Director and/or Chief of Staff when requested.

REAPPOINTMENT MAINTENANCE OF PRIVILEGE

- Demonstrated evidence of clinical activity from relevant professional practice evaluation during the past 24 months without significant quality variations, OR
- Peer recommendations when performance data is insufficient at the time of reappraisal; and
- Ongoing maintenance of continuing medical education as it pertains to scope of license and specialty.

SECTION II – PRIVILEGES REQUESTED

Basic Privileges	**Requested**	**Granted**	**Denied**
Evaluate & Diagnose			
Provide consultation to determine need for surgical intervention			
Order medications			
Post- surgical evaluation and treatment			

Surgical Procedures	**# Procedures in last 12 months**	**Requested**	**Granted**	**Granted w Conditions**	**Denied**
Alveolectomy					
Benign oral cavity tumors, excision					
Benign tumor of maxilla (excluding maxillary sinus), excision					
Benign tumors of mandible, excision					
Bone graft to mandible					
Closed and open reduction of fractures of maxilla and					

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Surgical Procedures	# Procedures in last 12 months	Requested	Granted	Granted w Conditions	Denied
mandible					
Full bony impacted teeth, excision					
Harvesting of skin grafts					
Infections of dento-alveolar structures with spread to contiguous areas, drainage					
Local infiltration of anesthesia					
Ludwig's angina, I & D					
Malignant tumors originating in dental arches, excision					
Mcrognathia, surgical correction					
Mucocele, excision					
Partially bony impacted teeth, extraction					
Preprosthetic surgery					
Prognathism, surgical correction					
Salivary gland, excision					
Teeth, extraction					
Temporo-mandibular joint dislocation, closed reduction					
Temporo-mandibular joint dislocation, open reduction					
Topical aesthesia					

Invasive Procedure	# Procedures in last 12 months	Requested	Granted	Granted w Conditions	Denied
Laryngoscopy					

I have been approved for these procedures at the following hospitals/ambulatory surgery centers

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SECTION III - ACKNOWLEDGE OF PRACTITIONER:

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at the Hospital. I hereby attest that the references, reports, records and information are available that verify my qualifications and competency to practice as requested.

I understand that:

1. In exercising any clinical privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
2. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.
3. The use of any other new, untried, or unproven procedure/treatment modality/instrumentation maybe performed or used, only after the regular credentialing process has been completed and the privilege to perform or use said procedure/treatment modality/instrumentation has been granted to the individual practitioner.

_____ _____
SIGNATURE OF APPLICANT **DATE**

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SECTION IV – RECOMMENDATIONS AND APPROVALS

Recommendation of the Medical Director:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

_____ Recommend all requested privileges

_____ Recommend the following privileges with conditions:
_____

_____ Denial of the following privileges:
_____

_____ _____
Medical Director **Date**

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_____ _____
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Recommendation of the Medical Executive Committee:

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend the following action on the privileges:

_____ Recommend all requested privileges

_____ Recommend the following privileges with conditions:
_____

_____ Denial of the following privileges:
_____

_____ _____
Chief of Staff **Date**

Decision of the Governing Board:

The Governing Board has reviewed the above recommendations regarding the requested clinical privileges and supporting documentation for the above named applicant and has:

_____ approve all requested privileges

_____ approve the following privileges with conditions:
_____

_____ denied the following privileges:
_____

_____ _____
Chairman of the Board **Date**