

Regions Hospital

Delineation of Privileges

Oral & Maxillofacial Surgery

Applicant's Name: _____
Last
First
M
Date

Instructions: Applicants must provide complete names and addresses for their references. Please DO NOT SEND letters of recommendation along with your application. These must be primary source verified by Regions Hospital. If documentation of cases or procedures is required, please attach case and/or procedural logs to your privilege delineation.

CORE I- General Privileges Oral and Maxillofacial Surgery

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include admission, work-up, diagnosis, and provision of nonsurgical and surgical care to all patients of all ages presenting with illnesses, injuries and disorders of the Dental anatomy. Privileges include antral-oral/oral-nasal tract or fistula closure, cheiloplasty, correction of micro and macrognathia of facial skeleton and soft tissue, dental/alveolar defects, dental root tip recovery from the accessory facial sinuses, frenectomies, bone, nerve, skin grafting, infections or oral and perioral structures, maxillofacial surgery including open and closed reduction of facial bone fractures, maxilla, mandible, zygoma, malar, nasal, orbital, LeFort's I, II, III, application of arch bars, excision intra-oral lesions, partial glossectomy or glossoplasty procedures, periodontal surgery, placement of artificial implant in reconstruction, closed and open reduction of fractures of the mandible, maxilla, zygoma and arch, limited salivary gland and duct surgery.</p>	<ol style="list-style-type: none"> 1. DDS, DMD 2. Successful completion of an ADA accredited training program in Oral & Maxillofacial Surgery. 3. Board certified or eligible and progressing toward board certification by the American Board of Oral & Maxillofacial Surgery. 	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> 1. Need names and addresses of two (2) Oral & Maxillofacial Surgeons whom we may contact who can comment on the applicant's current clinical competence in the field of Oral & Maxillofacial Surgery. 2. If residency or fellowship has been completed within five years, also include name of chair from the training program. <p>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</p> <p>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> 1. Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact. <p>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____</p>

CORE II- Special Privileges in Oral & Maxillofacial Surgery

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
<input type="checkbox"/> Laser: Arthroscopic Temporomandibular Joint Procedures Rhinoplasty/Blepharoplasty <input type="checkbox"/> Other: List Type and Provide Documentation of Training: _____ _____ _____ _____	1. DDS, DMD 2. Successful completion of an ADA accredited training program in Oral & Maxillofacial Surgery. 3. Board certified or eligible and progressing toward board certification by the American Board of Oral & Maxillofacial Surgery.	<u>New Applicants:</u> 1. Documentation of coursework or training to perform procedure(s), or 2. Evaluation from residency Director or fellowship Director documenting previous experience to perform procedure(s). Please indicate names and addresses of the physicians whom we may contact. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____ <u>Reappointment Applicants:</u> 1. Documentation of a case load of the procedure(s), or 2. Documentation of additional course work of a particular procedure, or 3. Documentation of work with a given preceptor, or 4. Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax: _____

TO BE COMPLETED BY APPLICANT:

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges will not proceed until which time that the information is received.

Signature

Date

TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL:

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

Signature

Date