Regions Hospital
Delineation of Privileges
Otolaryngology

Applicant's Name:____ ____________________
Last **First** **M** **Date**

Instructions: **Applicants must provide complete names and addresses for their references. <u>Please DO NOT SEND letters of recommendation along with your application</u>. 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 Otolaryngology

Privileges	**Basic Education & Minimal Formal Training**	**Required Documentation and Experience**
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 head and neck affecting the ears, facial skeleton, and respiratory and upper alimentary system. These privileges include surgery involving temporal bone, nasal and paranasal sinuses, skull-base, maxillofacial area, thyroid, parathyroid, salivary glands, and the lymphatic tissue of the head and neck. The surgery may be an exterpative, esthetic, plastic or reconstructive nature. These do not include any of the special requests listed under the section entitled "Special Request for Privileges in Otolaryngology".	1. MD, DO, MBBS 2. Successful completion of an ACGME or AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency in Otolaryngology. 3. Board certified or eligible and progressing toward board certification in Otolaryngology.	<u>New Applicants:</u> Demonstration that applicant has provided inpatient services or performed surgery for at least 50 patients during the past 12 months in areas such as head and neck, otologic, plastic, reconstructive, and general otolaryngology surgery, **or** Names and addresses of two Otolaryngologists practicing in the community whom we may contact who can attest to your competency. Name:_________________________ Name of Facility:_________________________ Add:_________________________ Ph/Fax:_________________________ Name:_________________________ Add:_________________________ Ph/Fax:_________________________ <u>Reappointment Applicants:</u> Documentation of the provision of inpatient or consultation services to at least 50 patients in the last 24 months or the clinical equivalent, **or** 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:_________________________

☐ CORE II- Special Privileges Otolaryngology

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
Advanced otologic or neurotologic procedures: ☐ Facial Nerve Decompression (Medical to Geniculate Ganglion) ☐ Vestibular Neurectomy ☐ Surgery for Acoustic Neuroma	Same as Core I	New Applicants: Documentation of coursework or training to perform procedure(s), **or** Name and address of residency Director or fellowship Director whom we may contact who can document previous experience to perform procedure(s), **or** Demonstrated competency to Regions Hospital Division/Section Head of Otolaryngology. Name:__________ Name of Facility:__________ Add:__________ Ph/Fax:__________ Reappointment Applicants: Documentation of procedure(s) performed within the past 24 months, **or** 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:__________
Plastic and Reconstructive Procedures: ☐ Rhytidectomy ☐ Blepharoplasty ☐ Chemical Peel ☐ Free Flap Reconstruction (with Microvascular Anastomosis)	Same as Core I	New Applicants: **1.** Documentation of coursework or training to perform procedure(s), **or** 2. Name and address of residency Director or fellowship Director whom we may contact who can document previous experience to perform procedure(s), **or** 3. Demonstrated competency to Regions Hospital Division/Section Head of Otolaryngology. Name:__________ Name of Facility:__________ Add:__________ Ph/Fax:__________ Reappointment Applicants: **1.** Documentation of procedure(s) performed within the past 24 months, **or** 2. 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:__________

☐ Special Privileges Otolaryngology (Continued):

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
Advanced Maxillofacial Procedures: ☐ Cleft Lip/Palate Repair ☐ Orthognathic Procedures ☐ Temporomandibular Joint Surgery	Same as Core I	New Applicants: **1.** Documentation of coursework or training to perform procedure(s), **or** **2.** Name and address of residency Director or fellowship Director whom we may contact who can document previous experience to perform procedure(s), **or** 3. Demonstrated competency to Regions Hospital Division/Section Head of Otolaryngology. Name:__________ Name of Facility:__________ Add:__________ Ph/Fax:__________ Reappointment Applicants: 1. Documentation of procedure(s) performed within the past 24 months, or 2. 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:__________

☐ **Special Privileges Otolaryngology (Continued):**

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
☐ Laser Utilization ☐ Holium ☐ CO2 ☐ Argon ☐ KTP ☐ Other Specify Type(s): __________________________ __________________________	Same as Core I	New Applicants: **1.** Documentation of coursework or training to perform procedure(s), **or** **2.** Name and address of residency Director or fellowship Director whom we may contact who can document previous experience to perform procedure(s), **or** **3.** Demonstrated competency to Regions Hospital Division/Section Head of Otolaryngology, **or** 4. Completion of an approved laser course that includes: • Laser Physics • Laser Safety (as it pertains to the patient, operator and others in the operating theatre) • Actual hands-on or laboratory experience associated with the laser clinical privileges requested. Name:______________________________ Name of Facility:______________________ Add:______________________________ Ph/Fax:___________________________ Reappointment Applicants: **1.** Documentation of procedure(s) performed within the past 24 months, **or** 2. 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 DIVISION/SECTION HEAD:

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