Regions Hospital
Delineation of Privileges
Oral & Maxillofacial Surgery

Applicant’s Name: __________________________________________

Instructions:
• Place a check-mark where indicated for each core group you are requesting.
• Review education and basic formal training requirements to make sure you meet them.
• Review documentation and experience requirements and be prepared to prove them.
  ✓ Note all renewing applicants are required to provide evidence of their current ability to perform
    the privileges being requested
  ✓ When documentation of cases or procedures is required, attach said case/procedure logs to this
    privileges-request form.
• Provide complete and accurate names and addresses where requested -- it will greatly assist how
  quickly our credentialing-specialist can process your requests.

Overview
Core I  – General privileges in oral and maxillofacial surgery

Special privileges:
• Laser
• Temporomandibular joint procedures
• Rhinoplasty
• Blepharoplasty

Moderate sedation
Core procedure list
Signature page
<table>
<thead>
<tr>
<th>CORE I — General staff privileges oral &amp; maxillofacial surgery</th>
</tr>
</thead>
</table>

### Privileges

Admission, work-up, diagnosis, and provision of nonsurgical and surgical care to 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.

### Basic education and minimal formal training

1. DDS or DMD
2. Completion of an approved ADA- or Royal College of Physicians and Surgeons of Canada accredited training program in oral & maxillofacial surgery.
3. Current certification or active participation in the examination process, with achievement of certification within 5 years, leading to board certification by the American Board of Oral & Maxillofacial Surgery.

### Required documentation and experience

**NEW APPLICANTS:**

1. Provide contact information for two (2) oral & maxillofacial surgeons whom the credentialing specialist may contact to provide an evaluation of your clinical competency.

| Name: ______________________________________ | Name: ______________________________________ |
| Name of Facility: ____________________________ | Name of Facility: ____________________________ |
| Address:_____________________________________ | Address:_____________________________________ |
| Phone: ________________    Fax: ________________ | Phone: ________________    Fax: ________________ |
| Email: _______________________________________ | Email: _______________________________________ |

2. If residency or fellowship has been completed within five years, provide contact information for the chair of the training program.

| Name: ____________________________________________ |
| Name of Facility: ________________________________ |
| Address:________________________________________ |
| Phone: ________________________    Fax: ________________ |
| Email: __________________________________________ |

**REAPPOINTMENT APPLICANTS:**

1. Provide contact information for a physician peer whom the credentialing specialist may contact to provide an evaluation of your competency.

| Name: ____________________________________________ |
| Name of Facility: ________________________________ |
| Address:________________________________________ |
| Phone: ________________________    Fax: ________________ |
| Email: __________________________________________ |
Special privileges, Oral & Maxillofacial surgery - check those you are requesting

<table>
<thead>
<tr>
<th>Privilege</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Laser</td>
</tr>
<tr>
<td>☐ Rhinoplasty</td>
</tr>
<tr>
<td>☐ Blepharoplasty</td>
</tr>
<tr>
<td>☐ Temporomandibular joint procedures</td>
</tr>
</tbody>
</table>

### Basic education and minimal formal training

1. DDS or DMD
2. Completion of an approved ADA- or Royal College of Physicians and Surgeons of Canada accredited training program in oral & maxillofacial surgery.
3. Current certification or active participation in the examination process, with achievement of certification within 5 years, leading to board certification by the American Board of Oral & Maxillofacial Surgery.

### Required documentation and experience

**NEW APPLICANTS:**

1. Provide documentation of coursework or training to perform selected procedure(s);
   Or
   Provide contact information for the residency director or fellowship director whom the credentialing specialist may contact to provide an evaluation of your clinical competency to perform selected procedure(s).

   Name: ______________________________________________________

   Name of Facility: _____________________________________________

   Address: ____________________________________________________

   Phone: ________________________    Fax: _______________________

   Email: ______________________________________________________

**REAPPOINTMENT APPLICANTS:**

1. Provide case load of performing the selected procedure(s);
   Or
   Provide documentation of additional course work related to the selected procedure(s);
   Or
   Provide documentation of work with a given preceptor related to the selected procedure(s);
   Or
   Provide contact information for a physician peer whom the credentialing specialist may contact to provide an evaluation of your competency to perform the selected procedure(s).

   Name: ______________________________________________________

   Name of Facility: _____________________________________________

   Address: ____________________________________________________

   Phone: ________________________    Fax: _______________________

   Email: ______________________________________________________
Core Procedure List — Oral & Maxillofacial Surgery

To the applicant: Strike though those procedures you do not wish to request.

This list is a sampling of procedures included in the core. This is not intended to be all-encompassing but rather reflective of the categories/types of procedures included in the core.

- Performance of history and physical exam
- Dentoalveolar surgery, including management of odontogenic infections, and erupted, un-erupted, and impacted teeth, including third-molar extractions and defects and deformities of the dentoalveolar complex
- Trauma surgery, including tracheostomies, open and closed reductions of fractures of the mandible, maxilla, zygomatico-maxillary, nose, naso-frontal-orbital-ethmoidal and midface region, and repair of facial, oral and soft-tissue injuries and injuries to specialized structures
- Pathology, including major maxillary sinus procedures, treatment of temporomandibular joint pathology, cystectomy of bone and soft tissue, sialolithotomy, sialoadenectomy, management of head and neck infection, including incision and drainage procedures, fifth-nerve surgery, and surgical management of benign and malignant neoplasms
- Reconstructive and cosmetic surgery, including bone grafting and soft tissue grafting procedures and the insertion of implants (distant bone graft sites may include but are not limited to the calvaria, rib, ilium, fibula and tibia; distant soft tissue grafts include but are not limited to cartilage, skin, fat, nerve, and fascia); reconstructive surgery procedures include vestibuloplasties, augmentation procedures, temporomandibular joint reconstruction, management of continuity defects, insertion of craniofacial implants, facial cleft repair, and other reconstructive surgery of the oral and maxillofacial region.
- Orthognathic surgery includes the surgical correction of functional and aesthetic orofacial and craniofacial deformities of the mandible, maxilla, zygoma and other facial bones; surgical procedures include ramus and body procedures, subapical segmental osteotomies, LeFort I, II and III procedures, and craniofacial operations (determine whether LeFort I and craniofacial operations are core or non-core)
ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which – by education training, current experience and demonstrated performance – I am qualified to perform and that I wish to exercise at Regions Hospital. I understand that:

1. In exercising any clinical privilege granted, I am governed by Regions Hospital and Regions Medical Staff policies and rules applicable generally and any applicable to the particular situation.
2. In an emergent situation I may perform a procedure for which I am not privileged when no practitioner holding the applicable procedure is available to respond to the emergency.

I agree to supply Regions Hospital Medical Staff Services (or designee) with all the information that has been requested of me for the privileges that I have applied for. I also understand that my application for privileges will not proceed until the information is received.

________________________________________________________________________  ___________________________________________________________________
Signature       Date

DIVISION / SECTION HEAD RECOMMENDATION

I have reviewed and/or discussed the clinical privileges requested and supporting documentation for the above-named applicant and make the following recommendation/s:

☐ Recommend all requested privileges

☐ Recommend privileges with the following conditions/modifications

☐ Do not recommend the following requested privileges

<table>
<thead>
<tr>
<th>Privilege</th>
<th>Condition / Modification / Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>

Notes:

________________________________________________________________________  ___________________________________________________________________
Signature       Date
# Regions Hospital
## Moderate Sedation

### Privilege

- Administer and manage moderate sedation/analgesia, a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accomplished by light tactile stimulation. A patent airway is maintained and spontaneous ventilation is adequate. Cardiovascular function is always maintained.

### Basic education and minimal formal training

1. MD, DO, MBBS, MB BCH, DPM, DMD, DDS,
2. Successful completion of an ACGME or AOA or Royal College of Physicians and Surgeons of Canada, approved residency training program.
3. Current ACLS, ATLS or PALS certification.

### Required documentation and experience

#### NEW APPLICANTS:
1. Provide documentation of successful completion of an examination provided by the Regions medical staff services  
   Or  
   Document experience by providing one of the following:
   - Evidence of successful completion of a moderate sedation test with passing score from another hospital;
   - Governing board letter from another hospital indicating the applicant has moderate sedation privileges;
   - Letter from Medical Staff Office at another hospital indicating specifically that the practitioner has moderate sedation privileges and the date they were granted;
   - If a recent graduate, attestation of competency from program director.
2. Provide documentation of current ACLS, ATLS or PALS certification.

#### REAPPOINTMENT APPLICANTS:
1. Provide documentation of performing moderate sedation for at least ten (10) patients within the past 24 months;  
   Or  
   Provide documentation from Division/Section Head that attests to ongoing current competence.
2. Provide documentation of current ACLS, ATLS or PALS certification.

### TO BE COMPLETED BY APPLICANT:
I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information being requested of me for the privileges I am applying for. I understand my application for privileges will not proceed until 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 this applicant’s training and experience. I recommend this application proceed.

__________________________  _______________________
Signature               Date