Surgical Privileges Form:
ORL - HNS

Clinical Privileges Request

Applicant's Name: …… Scope of Practice: …… License No. (If Any): …….. Facility: ……..

Date: …….. Place of Work: ……..

CATEGORY I: OTOLOGY PROCEDURES

Privileges	*(To be completed by the applicant)*	(For committee use)		Recommended (For committee use)
		Under Supervision	Independent	
1. Pinna-plasty				
2. Ossiculoplasty				
3. Stapedectomy				
4. Mastoidectomy				
a. Canal wall up				
b. Simple				
c. Modified radical				
d. Radical				
5. Mastoid reconstruction				
6. Tympanic neurectomy				
7. Cochlear implantation				
8. Facial nerve exploration				

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9. Labyrinthectomies				
10. Surgery for hydrops lymphaticus				
11. Excision of glomus tumor				
a. Glomus tympanicum				
b. All other types				
12. Petrosectomy				
a. Partial				
b. Total				
13. Middle fossa approach				
14. Posterior fossa approach				
15. Ear canal osteoma excision				
16. Use of laser				
a. CO2 (to assist in otological surgery)				
b. KTP (to assist in otological surgery)				
17. Use of navigation (to assist in ontological surgery)				
18. Radiofrequency assisted operation				
19. Coblation assisted operation				

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CATORGY II: RHINOLOGY PROCEDURES

Privileges	Requested *(To be completed by the applicant)*	Recommended (For committee use)		Not Recommended (For committee use)
		Under Supervision	Independent	
2. Septal reconstruction				
3. Reconstruction of septal perforation				
4. Caldwel-luc operation				
5. Maxillary artery ligation				
6. Nasal polypectomy				
7. Rhinoplasty				
a. External approach				
b. Internal approach				
8. Lateral rhinotomy				
9. Ligation of sphenpalatine artery				
10. FESS				
11. Classical sinus surgical operations				
a. Intranasal:				
i. maxillary antrectomy & antrostomy				
ii. anterior ethmoidectomy				
iii. posterior ethmoidectomy				
iv. sphenoidectomy				
b. External:				

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i. Ethmoidectomy external				
ii. Frontal trephination				
iii. Frontal ethmoidectomy				
iv. Frontal sinus obliteration				
v. Ligation of anterior ethmoidal cavity				
12. Transposition of the nose				
13. Maxillectomies				
a. Medial				
b. Total				
14. Osteoplastic flap operations				
15. Rhinoseptoplasty				
16. Use of laser				
c. CO2 (to assist in nasal surgery)				
d. KTP (to assist in nasal surgery)				
17. Use of navigation (to assist in nasal surgery)				

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Name of Applicant: ----------

CATEGORY III: LARYNX, HEAD AND NECK SURGERIES

Privileges	*(To be completed by the applicant)*	(For committee use)		Recommended (For committee use)
		Under Supervision	Independent	
1. Uvulopalatopharyngoplasty				
2. Partial glossectomy				
3. Dohlman's procedure				
4. Various neck flaps				
5. Total laryngectomy				
6. Pharyngolaryngectomy				
7. Partial laryngectomy				
8. Voice restoration procedures				
9. Neck dissection				
10. Thyroplasty				
11. Ranula excision				
12. Submandibular gland excision				
13. Superficial parotidectomy				
14. Thyroglossal cyst excision				
15. External carotid artery ligation				
16. Neck lymph node biopsy				
17. Excision of branchial cyst				

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18. Laryngo-fissure				
19. Excision of pharyngeal pouch				
20. LAUP				
21. Throidectomy (all types)				
22. Aryepiglottoplasty				
23. Use of laser				
a. CO2 (to assist in nasal surgery)				
b. KTP (to assist in nasal surgery)				
24. Use of navigation (to assist in larynx, head and neck surgery				
25. Vocal folds (cords) injection with various materials (e.g fat, Teflon, etc)				
26. Botilinum toxin injection in the circopharyngeal sphincter				

CATEGORY IV: AUDIOLOGY PROCEDURES

1. Video nystagmography and caloric testing				
2. Rotatory chair test				
3. Hearing aids assessment and programming				
4. Auditory brain stem evoked response testing (with or without sedation)				
5. Cochlear implant programming procedure				
6. Auditory rehabilitation technique				

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CATEGORY V: Additional Privileges (not included above)

1.				
2.				
3.				
4.				
5.				
6.				

Notes:

- If additional privilege(s) are desired, please indicate this in the space provided above.
- You must submit along with this application all necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.

By signing below, I acknowledge that I have read, understand, and agree to abide by QCHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

a) In exercising any clinical privileges granted, I am constrained by QCHP's policies and rules applicable generally and any applicable to the particular situation.

b) 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 recognized policies and rules.

…….. ……

Applicant's signature (Stamp if any) Date

…….. ……

1. Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signature Date

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For Committee use only

Evaluation Committee Chairman:

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and I have made the above-noted recommendation(s).

…….. ……

Chairperson's Stamp & signature Date

Other Committee Members:

…….. ……

1) Name Date

…….. ……

2) Name Date

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