MILLARD FILLMORE SURGERY CENTER

Name _____ **Date** _____

DELINEATION OF PRIVILEGES - ORAL AND MAXILLOFACIAL SURGERY

Credentialing period effective for 2 years

LEVEL I (CORE) PRIVILEGES *Those procedures which are assumed to have been mastered following satisfactory completion of an approved oral and maxillofacial surgical training program and which can be performed by any oral and maxillofacial surgeon*
Surgical removal of teeth
Removal of impacted teeth
Exposure of unerupted teeth
Tongue ties – ankyloglossia
Incision and drainage
Administration of local anesthesia

LEVEL I (CORE) PRIVILEGES (CON'T)
Biopsy and excision of bone and soft tissue
Reduction of Facial fractures
Arthroscopic examination of TMJ's
Restorative Dental Procedures
Surgical root canals and apicoectomy
Laser Surgery

LEVEL I (CORE) PRIVILEGES	**PHYSICIAN REQUEST**		**Granted**	**Not Granted***	**With Following Requirements** (Provide Details)**
LEVEL II PRIVILEGES *Those procedures which categorically require documentation of additional training or significant experience, such as high risk or new procedures. (Volume Criteria may be applicable.)*	**PHYSICIAN REQUEST**		**Granted**	**Not Granted***	**With Following Requirements** (Provide Details)**

KEY *NOT GRANTED DUE TO (Provide Details Below)	**WITH FOLLOWING REQUIREMENTS (Provide Details Below)
1) Lack of Documentation	1) With Consultation
2) Lack of Required Training/Experience	2) With Assistance
3) Lack of Current Competence (Databank Reportable)	3) With Proctoring
4) Other (Please Define) (i.e., Exclusive Contract)	4) Other (Please Define)

DETAILS:_____

_____

National Practitioner Databank Disclaimer Statement: - Kaleida Health must report to the National Practitioner Data Bank when any clinical privileges are not granted for reasons related to professional competence or conduct. (Pursuant to the Health Care Quality Improvement Act of 1986 (43 U.S.C. 11101 et seq.)

_____/_____

Signature of Applicant **Date**

I recommend approval of the procedures requested by the applicant: ____ as requested ____ as amended

_____/_____

Signature of Clinical Chief **Date**

APPLICANT: PLEASE RETAIN A COPY OF THIS SIGNED DELINEATION FOR YOUR RECORDS

(ASC-ORAL/mso-Reviewed & Revised-09/11)