Applicant's Name

_____

ORAL AND MAXILLOFACIAL SURGERY

I hereby request surgical privileges in the specialty of Oral and Maxillofacial Surgery as shown in this form. I understand that privileges granted are subject to a bi-annual review coinciding with reapplication for medical staff membership. I also understand that application for additional or new procedures can be made at any time with proper documentation.

Applied for	**Approved**	
❑ DENTOALVEOLAR SURGERY Includes, but is not limited to, surgery involving the teeth and their supporting structures	❑ YES	❑ NO
❑ MAXILLOFACIAL SURGERY Includes but is not limited to, surgical management of injuries to the maxillofacial structures	❑ YES	❑ NO
❑ GENERAL RECONSTRUCTIVE SURGERY Includes, but is not limited to, the reconstruction of maxillofacial	❑ YES	❑ NO
❑ PRE-PROSTHETIC RECONSTRUCTIVE SURGERY Includes, but is not limited to, surgical preparation of the mouth for wearing prosthesis; placement of implants	❑ YES	❑ NO
❑ SURGICAL TREATMENT OF PATHOLOGY OF MAXILLOFACIAL STRUCTURES Includes, but is not limited to, surgical management of cysts, simple neoplasms, salivary gland diseases	❑ YES	❑ NO
❑ ORTHOGNATHIC RECONSTRUCTIVE Includes but is not limited to osteotomies for correction of growth discrepancies of the jaws and their contiguous structures	❑ YES	❑ NO
❑ TEMPORAMANDIBULAR JOINT SURGERY Includes, but not limited to surgical management of dysfunctions of the TMJ	❑ YES	❑ NO
❑ **HISTORY AND PHYSICAL**	❑ YES	❑ NO
❑ **Radiography Use of Modality & interpretation of images (therapeutic and diagnostic)**	❑ YES	❑ NO
❑ **Ultrasound Use of Modality & interpretation of images (therapeutic and diagnostic)**	❑ YES	❑ NO
❑ **Fluoroscopy Use of Modality with State License & interpretation of images (therapeutic and diagnostic**)	❑ YES	❑ NO
❑ **Local anesthesia**	❑ YES	❑ NO
❑ **Conscious Sedation**	❑ YES	❑ NO
❑ **Supervision of Conscious Sedation Trained Registered Nurse**	❑ YES	❑ NO
❑ OTHERS NOT LISTED	❑	❑

❑	❑ YES	❑ NO
❑	❑ YES	❑ NO
❑	❑ YES	❑ NO

Signature of Applicant _____ Date _____

Signature of MEDICAL DIRECTOR _____ DATE _____

Signature of Governing Body chairperson _____ Date recommended _____