# Surgical Privileges Form: Otolaryngology (Core Privileges)

Clinical Privileges Request

Applicant's Name: …… Scope of Practice: ……

License No. (If Any): …… Facility: ……

Date: ……

## Core Privileges

| Privileges | For applicant use | | For committee use | | |
|---|---|---|---|---|---|
| | *Request* | *Signature* | *Recommen -ded* | *Not Recommended* | *Signature* |

**Category I : Otology procedures**

| | | | | | |
|---|---|---|---|---|---|
| 1. Examination of Ear | | | | | |
| a. LA | | | | | |
| b. GA | | | | | |
| 2. Myringotomy with or without tubes | | | | | |
| 3. Removal of foreign body (aural) | | | | | |
| 4. Aural packing | | | | | |
| 5. Ear syringing | | | | | |

## Category II : Rhinology Procedures

| | | | | | |
|---|---|---|---|---|---|
| 1. Examination of the nose | | | | | |
| a. LA | | | | | |
| b. GA | | | | | |
| 2. Nasal cautery | | | | | |
| 3. Submucus diathermy (SMD) of turbinate | | | | | |
| 4. Nasal endoscopy | | | | | |
| 5. Antrostomy inferior (non-endoscopic) | | | | | |
| 6. Turbinectomy | | | | | |
| 7. Antral wash | | | | | |
| 8. Nasal fracture reduction (anterior and posterior) | | | | | |
| 9. Removal of foreign body | | | | | |
| 10. Flaryng packing | | | | | |
| 11. Septoplasty (No revision septoplasty) | | | | | |
| 12. Evacuation of septal hematoma | | | | | |
| 13. Sinus endoscopy (Rigid + fibro optic) | | | | | |

## Category III : Larynx, Head and neck Surgeries

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Examination of the larynx | | | | | | |
| a) LA | | | | | | |
| b) GA | | | | | | |
| 2. I&D Quinsy | | | | | | |
| 3. Tonsillectomy | | | | | | |
| 4. Adenoidectomy | | | | | | |
| 5. Tongue tie release | | | | | | |
| 6. PNS Examination/Biopsy | | | | | | |
| 7. Oropharynx examination/biopsy | | | | | | |
| 8. Fibro optic endoscopy | | | | | | |
| 9. Rigid endoscopy (all) | | | | | | |
| 10. Tracheostomy | | | | | | |

## Category IV : Audiology Procedure

| | | | | | |
|---|---|---|---|---|---|
| 1. Full audiological diagnostic procedure including: PT audiometric test battery, Tym panometry test battery, Otoacoustic emission testing, speech audiometry, and Behavioral hearing testing including VRA. | | | | | |
| 2.Particle reposition maneuver for BPPV | | | | | |
| 3.Vestibular rehabilitation exercise | | | | | |
| 4.Pure tone audiogram | | | | | |
| 5.Speech audiometry | | | | | |
| 6.Tympanometry | | | | | |
| 7.Acoustic reflex | | | | | |
| 8.Otoacoustic emission | | | | | |
| 9.Behavioural test | | | | | |

**Note:**

- 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.
- Granting privileges under supervision is no longer permitted

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

## 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