McLaren GREATER LANSING

DEPARTMENT OF SURGERY
OTORHINOLARYNGOLOGY SECTION

Privilege Request Form

APPLICANT'S NAME: _____
(Please Print)

In conjunction with my appointment to the Professional Staff, I request the privileges checked below. As consistent with the Credentialing Policy of the Otorhinolaryngology Section, I understand that supporting documentation must be provided, as applicable, and that if supporting documentation is not provided, this request will not be considered complete.

SCOPE OF PRIVILEGES: Scope of privileges includes admission, work up, diagnosis, and provision of nonsurgical and surgical care to patients of all ages presenting with illnesses, injuries, and disorders of the head and neck affecting the ears, facial skeleton, respiratory, and upper alimentary system.

BRONCHOESOPHAGOLOGY SURGERY
____ Bronchoscopy
____ Esophagoscopy
____ Laryngoscopy (If laser is involved, separate documentation of experience is required)
____ Mediastinoscopy

HEAD & NECK SURGERY
____ Excision neck masses
____ Excision salivary glands (with or without nerve grafting)
____ Laryngectomy surgery
____ Major vessel ligation
____ Neck dissection
____ Oropharyngeal resection
____ Thyroidectomy

PLASTIC/RECONSTRUCTIVE SURGERY
____ Blepharoplasty
____ Bone grafting
____ Cartilage or other connective tissue grafting
____ Flap reconstruction
____ Hair transplantation
____ Liposuction
____ Mentoplasty
____ Repair cleft lip and/or palate
____ Rhinoplasty
____ Rhytidectomy
____ Skin grafting

EAR SURGERY
____ Middle ear surgery (all types)
____ Myringotomy
____ Neurotologic surgery (If craniotomy is included, separate documentation of specific experience is required.)
____ Otoplasty
____ Reconstructive procedure on auricle
____ Tympanomastoid surgery

NOSE/PERANASAL SURGERY
____ Ethmoid sinus surgery (all types)
____ Frontal sinus surgery
____ Maxillary sinus surgery (all types)
____ Maxillary fractures
____ Nasoseptal surgery
____ Polypectomy
____ Repair choanal atresia
____ Rhinoplasty
____ Sphenoid surgery (Incl. hypophysectomy)
____ Endoscopic sinus surgery

MAXILLOFACIAL SURGERY
____ Repair facial fractures (all types)

THROAT SURGERY
____ Tonsillectomy and/or adenoidectomy

DEPARTMENT OF SURGERY
OTORHINOLARYNGOLOGY SECTION

MISCELLANEOUS

____ Laser surgery
____ Yes*
____ No

*Must complete separate Laser Privileges Request Form.

____ Other (please specify)**

_____

_____

**Other procedures may require referral to another Department or Section

_____ _____
Applicant's Signature *Date*

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For Office Use Only

Recommendations:
( ) Approve as requested.
( ) Approve with modifications as noted below.
( ) Denial of privileges.

Modifications:

_____
_____
_____

I (we) attest that in recommending these privileges, due consideration has been given to the applicant's professional performance, training, experience, judgment, and technical skills.

_____ _____
Chairman, Otorhinolaryngology Section *Date*

_____ _____
Chairman, Department of Surgery *Date*

_____ _____
Co-Chief of Staff, (if requesting interim privileges) *Date*

Action:

Credentials Committee Date: _____
Executive Committee Date: _____
Board of Trustees Date: _____
Comments: _____
_____
_____

MCLAREN GREATER LANSING

LASER PRIVILEGE REQUEST FORM

Applicant's Name: _____
(Please Print)

Specialty: _____

Instructions: Please complete this form and submit it to Medical Staff Services with appropriate documents.
Note: Prior or concurrent approval of the applicable associated clinical procedure(s)/privilege(s) is a pre-requisite for a favorable recommendation on a request for laser privileges.

Type of laser wave length available at McLaren Greater Lansing for which you are requesting privileges:

CO_2 Laser
____ Endoscopy
____ Laparoscopy
____ Open surgical
____ Arthroscopy

ND: YAG Laser
____ Endoscopy
____ Laparoscopy
____ Open surgical
____ Arthroscopy
____ Intravascular

ND: YAG Ophthalmic Laser
____ Q Switched
____ Contact

Holmium
____ Candela lithotriptor

Pulsed Dye Laser
____ Arthroscopy

____ **Excimer Laser**

____ **GreenLight PVP Laser**

Physics and safety lecture attended: _____ Date: _____

_____ _____
Applicant's Signature *Date*

****

For Office Use Only

Recommendations:
( ) Approve as requested.
( ) Approve with modifications as noted below.
( ) Denial of privileges.

Modifications:
_____
_____
_____

I (we) attest that in recommending these privileges, due consideration has been given to the applicant's professional performance, training, experience, judgment, and technical skills.

_____ _____
Chairman, Otorhinolaryngology Surgery Section *Date*

_____ _____
Chairman, Department of Surgery *Date*

_____ _____
Co-Chief of Staff (only if requesting interim privileges) *Date*

Action:
Credentials Committee Date: _____
Professional Staff Executive Committee Date: _____
Board of Trustees Date: _____
Comments:_____
_____