



FOOTHILL PRESBYTERIAN HOSPITAL
Glendora, California 91741

CRITERIA FOR GRANTING OTOLARYNGOLOGY-HEAD & NECK SURGERY PRIVILEGES

Please review these categories carefully to determine those privileges for which you are qualified. Indicate your request below by checking the appropriate category. If you feel that special training or experience qualifies you for advanced privileges, please contact the surgery department chair.

MINIMAL FORMAL TRAINING REQUIREMENTS:

Physicians requesting privileges should have successfully completed an approved Otolaryngology Surgery Residency Program and be board certified or eligible specialty. By virtue of the above, the physician has privileges to admit patients, perform general physical examinations, review systems/labs and other studies, manage patients and discharge patients.

PROCTORING REQUIREMENTS: *In accordance with the Medical Staff Bylaws and the requirements of the Joint Commission on Accreditation of Healthcare Organizations, each new applicant and reappointee (asking for new privileges) to the medical staff of Foothill Presbyterian Hospital must have a minimum of six cases proctored. Three must be proctored by an Active or Courtesy staff member of the surgery department and an additional three may be accepted from another facility, if proctored by a member of the FPH medical staff.*

We will appreciate your assistance and cooperation in ensuring that this is accomplished. To assist us, we are requesting that for your first six cases or until otherwise notified, you obtain a proctor for your surgical cases. Your proctor is named in your "Welcome to the Staff" letter. A list of other available proctors is attached for your convenience. You should have no more than one-third of your proctored cases proctored by an associate in your office.

The proctored cases should be representative of the privileges you are requesting in your specialty. If you are unable to obtain a proctor, please call the Medical Staff Office and they will be happy to assist you. In the case of an emergency operative procedure, you may proceed without a proctor, only with the approval of the chief of your department or his or her designee.

Please be aware that proctors may intervene regarding proposed treatment during a procedure if they deem in their judgment that it is absolutely necessary. On completion of the required number of proctored cases, the surgery department will review and evaluate these reports. You will be advised of the decision regarding your satisfactory completion of proctoring or if there will need to be additional proctoring requirements. We are sure you understand the need to require your cooperation in these efforts. These are not only mandated requirements, but they are essential to the maintenance of the quality of care established by the medical staff at Foothill Presbyterian Hospital. Again, we appreciate your assistance in this matter.

GENERAL ENT

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	General ENT	APPROVED	DENIED
<input type="checkbox"/>	_____	I&D Abscess/Hematoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Repair Skin Lacerations	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Skin Grafts & Flaps	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Skin Lesions & Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Pedicle Flap	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Cartilage & Bone Grafts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Implants	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Scar Revisions	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Cryosurgery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Laser Surgery	<input type="checkbox"/>	<input type="checkbox"/>

EAR

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	EAR	APPROVED	DENIED
<input type="checkbox"/>	_____	Myringotomy with/without tubes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Stapedectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Tympanoplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Mastoidectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Tympanomastoidectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Vidian Neurectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Excision ear & Mastoid Tumors	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Myringoplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Fenestration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Stapes Mobilization	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Facial Nerve Decompression & Repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Labyrinthectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Sacculotomy	<input type="checkbox"/>	<input type="checkbox"/>

REPAIR FRACTURES/FACIAL MAXILLARY

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Repair Fractures/ Facial Maxillary	APPROVED	DENIED
<input type="checkbox"/>	_____	Zygoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Malar Complex	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	LaFort Type I-II-III	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Orbital Floor Fracture	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Repair Facial Fracture	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	TMJ Exploration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Mandibular Condylectomy	<input type="checkbox"/>	<input type="checkbox"/>

HEAD & NECK

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Head and Neck	APPROVED	DENIED
<input type="checkbox"/>	_____	Glossectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Floor of Mouth Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Mandibulectomy with/without Neck Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Partial Pharyngectomy with Flap Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Tracheotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Laryngectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Lymph Node Biopsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Radical Node Dissection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Parotid Gland Surgery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Lip and Tongue Surgery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Radical Neck Dissection/ Modified Neck Dissection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Thyroglossal Duct Cyst	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Branchial Cleft Cyst	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Pharyngo-esophageal Diverticuli	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Incision and Drainage Abscess	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Excision Submandibular Gland	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Excision Neck Mass	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Thyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Excision Nasopharyngeal tumor	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Composite Resection (floor of mouth, tonsils, etc)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Lip Resection & Shave	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Diverticulectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Exploration Laryngeal Fracture	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Exploration Recurrent Laryngeal Nerve	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Arytenoidectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Thyroplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Tracheal Repair/Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Major Vessel Repair & Ligation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Excision Cystic Hygroma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Cleft Lip & Palate Repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Vocal Cord & Laryngeal Injections	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Parathyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>

ENDOSCOPY

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Endoscopy	APPROVED	DENIED
<input type="checkbox"/>	_____	Laryngoscopy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Tracheoscopy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Bronchoscopy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Esophagoscopy w/ dilatation	<input type="checkbox"/>	<input type="checkbox"/>

FACIAL PLASTIC SURGERY

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Facial Plastic Surgery	APPROVED	DENIED
<input type="checkbox"/>	_____	Rhytidectomy Cervico-Facial	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Rhytidectomy Eyelids	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Mentoplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Otoplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Rhinoplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Tracheoplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Laryngoplasty	<input type="checkbox"/>	<input type="checkbox"/>

NASAL AND SINUS

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Nasal and Sinus	APPROVED	DENIED
<input type="checkbox"/>	_____	Closed/Open Reduction Fractures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Polypectomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Septoplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Submucous Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Septo-Rhinoplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Para-Nasal Sinus Surgery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Caldwell Luc	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Antral Windows	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Radical Resection Maxilla	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Ethmoid Sinus Surgery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Trephine of Sinus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Osteoplasty of Frontal Sinus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Lateral Rhinotomy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Nasoseptal Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Open & closed Reduction Nasal Fracture	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Endoscopic Sinuses Surgery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Oralantral Fistula Repair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Choanal Atresia Repair	<input type="checkbox"/>	<input type="checkbox"/>

SPECIAL PROCEDURES – (Privileges require documented proof of training, skill, judgment, experience and competence through a residency or fellowship program or training in a recognized course that includes didactic and hands-on experience)

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	Special	APPROVED	DENIED
<input type="checkbox"/>	_____	Temporal Bone Resection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Endolymphatic Sac & Shunt Op.	<input type="checkbox"/>	<input type="checkbox"/>

On the basis of my training and experience, I am qualified to exercise and request the privileges which I have checked.

I have not requested privileges for any procedures for which I am not qualified. I am familiar with the laws of the State governing the practice of medicine and pledge to abide by these laws.

PRIVILEGES APPROVED: AS REQUESTED AS MODIFIED BELOW

Physician's Signature

Date

Chair, Surgery Department
fphent1 01/2010

Date