| LEVEL II | ADVANCED PRIVILEGED | REQUESTED | APPROVED | DENIED |
|---|---|---|---|---|
| **ORAL & MAXILLOFACIAL SURGERY** (continued) | | | | |
| • Cartilage/Bone Grafts | | | | |
| • Soft Tissue Excision | | | | |
| • Removal of Cyst or Tumor | | | | |
| • Removal of Exostoses | | | | |
| • Removal of Foreign Body/Maxilla/Mandible | | | | |
| • Removal of Bone Fragments | | | | |
| • Reduction Maxilla/Mandible related facial bones/Intermaxillary fixation | | | | |
| • Apicoectomy | | | | |
| • Retrograde Filling | | | | |
| • Surgical Fenestration | | | | |
| • Arch Bar Removal | | | | |
| • Vestibuloplasty | | | | |
| **PEDIATRIC DENTISTRY** | | | | |
| • Preventive/Interceptive Orthodontics | | | | |
| • Feeding Appliances | | | | |
| • Pediatric Prosthodontics | | | | |
| • Surgical Removal of Mesiodens/Supernumerary | | | | |
| **MISCELLANEOUS** | | | | |
| • Operating Room Privileges | | | | |
| • Moderate Sedation | | | | |

**Applicant:** I hereby request these privileges be granted in accordance with my training and experience.

Signature of Applicant _____ Date _____

DEPARTMENT CHAIR RECOMMENDATION:

□ I recommend all the clinical privileges as requested and approved.

□ I recommend those clinical privileges requested and approved; recommend denial of those clinical privileges identified as denied, For non-disciplinary cause or reason.

□ I recommend those clinical privileges requested and approved; recommend denial of one or more clinical privileges identified as denied, for medical disciplinary cause or reason explanation given below.

COMMENTS: _____

Chair Signature _____ Date _____

N:\Delination of Privilege Sheets\Dentistry.wpd

(Revised: July28, 2004)