


**AMBULATORY SURGERY DIVISION
REQUEST FOR PRIVILEGES
EAR, NOSE, THROAT**

Name: _____

Date: _____

The minimum education, training and experience qualifications for Medical Staff membership are delineated in the Medical Staff Bylaws, Rules and Regulations and/or Policies and Procedures of each facility. Please consult these documents prior to requesting privileges.

 Indicates privilege that is not available in this specialty at this facility.

To request privileges, please place an "X" in the appropriate facility column.

Bailey Square Surgery Center	Oakwood Surgery Center	Surgicare of South Austin	North Austin Surgery Center	Description of procedures for which privileges are requested:	Approved	Denied
				Abscess, I & D		
				Adenoidectomy		
				Bronchoscopy		
				Caldwell-Luc		
				Closed Reduction Nasal/Septal Fracture		
				Cyst, Excision		
				Esophagoscopy		
				Esophageal Dilation		
				Ethmoidectomy		
				Facial Nerve Decompression		
				Foreign Body Removal		
				Frenulectomy		
				IV Conscious Sedation		
				Laryngoscopy		
				Laser Laryngoscopy		
				Laser-Assisted Uvulo-Palatoplasty		
				Laser-Assisted Serial Tonsillectomy		
				Laser Excision of Lesion		
				Lesion, Excision		
				Mastoidectomy		
				Myringotomy, w/ or w/out tubes		
				Nasal Antral Windows		
				Nasal Cauterization		
				Nasal Polypectomy		
				Nasal Septal Reconstruction		
				Open Reduction Fracture		
				Palatoplasty - Assisted Uvular		
				Parotidectomy		
				Polypectomy		
				Rhinoplasty		
				Septoplasty		
				Sinus Endoscopy		
				Stapedectomy		
				Submucous Resecton		

Bailey Square Surgery Center	Oakwood Surgery Center	Surgicare of South Austin	North Austin Surgery Center	Description of procedures for which privileges are requested:	Approved	Denied
				Suspension Laryngoscopy		
				Suspension Laryngoscopy		
				Tonsillectomy w/ or w/out Adenoid		
				Tonsillectomy w/ CO2 Laser		
				Partial Thyroidectomy		
				Triple Endoscopy		
				Turbinate Reduction		
				Tympanoplasty		

___ Laser privileges requested (**certificate of training required**)

___ Extended Recovery, not to exceed 23 hours

___ Reads own xray/xray images (**must make note of findings in op report**)

If the condition/privilege you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and/or experience.

Based upon my training and experience, I hereby request privileges in the specialty of Ear, Nose, & Throat, as shown on this form. I understand that privileges granted to me may differ from those requested. I further understand that the completion of this form does not preclude me from requesting additional privileges in the future.

In exercising the privileges granted to me, I agree to strictly abide by the facility's Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures. I acknowledge that any restrictions on the clinical privileges granted to me are waived in an emergency/disaster situation, and in such a situation, my clinical privileges will be governed by the facility's Medical Staff Bylaws and Rules and Regulations.

Applicant's Signature & Date

DEPARTMENT RECOMMENDATION

I have reviewed the applicant's credentials and request for the above privileges. The following recommendations are made:

___ APPROVED ___ DENIED ___ DEFERRED ___ OTHER: _____

Department Chairperson's Signature & Date

GOVERNING BOARD APPROVAL

Approval Date per Minutes: ____/____/____
(Privileges expire one year from Approval Date.)