DELINEATION OF CLINICAL PRIVILEGES - ORAL & MAXILLOFACIAL SURGERY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

GENERAL: Oral and Maxillofacial surgery is the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of disease, injuries, deformities, defects and esthetic aspects of the oral and maxillofacial regions.

NOTE: This document is to be used in conjunction with DA Form 5440-13, Delineation of Clinical Privileges - General Surgery.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support	5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

Requested	Approved	
		a. Facial Trauma. Diagnosis and treatment of traumatic injuries to the facial hard and soft tissues.
		b. Pain Control. Diagnosis and treatment of orofacial pain to include therapeutic medications; local anesthesia; intravenous sedation, intramuscular sedation, inhalation sedation, and ambulatory general anesthesia.
		c. Pathology. Diagnosis and treatment of diseases, neoplasms, infections and other surgical conditions that affect the odontogenic apparatus and other contiguous hard and soft tissue structures.
		d. Dentoalveolar Surgery. Includes exodontia, alveoloplasty, exostosis removal, vestibuloplasty with soft tissue management of oral defects.
		e. Maxillofacial Skeletal Deformities. Surgical correction of maxillofacial deformities includes reconstructive procedures that correct deformities of the jaws, facial skeleton, and associated soft tissues. These abnormalities may be caused by genetic, environmental, developmental, functional and/or pathologic aberrations apparent at birth or manifested in subsequent growth and development, or acquired through trauma, neoplastic processes and degenerative diseases. The surgical procedures involve repositioning and recontouring the facial bones to correct functional or pathologic problems. Included are the repair, augmentation, or reconstruction using various osteotomies, autologous bone, cartilage, skin (full and split thickness), fat, allogeneic bone or appropriate alloplastic materials, and primary and secondary nerve graft repairs.
		f. Temporomandibular Joint. Diagnosis and treatment of conditions involving the temporomandibular joint including neoplasms, infections, degenerative/dislocation, myofascial and atypical facial pain. This involves open joint and closed joint/arthroscopy procedures and total joint reconstruction.
		g. Preprosthetic Surgery. Diagnosis and treatment of conditions involving the edentulous or partially edentulous jaw to include use of implantable devices/materials and augmentation with osseous, skin or mucosal grafts, harvested from donor sites by the Oral and Maxillofacial Surgery Service.
		h. History and Physical Examination. Physical evaluation of patients treated by the Oral and Maxillofacial Surgery Service with appropriate medical/surgical consultation.
		i. Diagnostic Procedures. Biopsy and other diagnostic procedures (e.g., laboratory studies, radiographic and arthroscopic) involving lesions or conditions of the facial structures, oral cavity, neck and skin. Included are tomograms, CAT scans, nuclear scans, and contrast studies.
		j. Salivary Glands. Diagnosis and therapeutic treatment of lesions or conditions of the salivary glands. Surgical treatment of benign lesions involving the major/minor sublingual and submandibular glands. Malignant neoplasms will be referred to the appropriate oncologic service.
		k. Maxillofacial Cosmetic Surgery. Cosmetic maxillofacial surgery encompasses those procedures designed to improve form and appearance of the maxillofacial region. Cosmetic surgery is performed on hard and soft tissues to correct maxillofacial adiposity and unattractive deformities of the chin, maxillofacial contour, eyelids, nasal structures, soft tissue of the face and neck, skin surface contour, hair and ear.
		l. Reconstructive oral and maxillofacial surgery. The surgical correction of soft and/or hard tissues defects of the jaws, face and contiguous structures, including reduction, revision, augmentation, grafting, and implantation for the correction or replacement of defective structures to assist in restoring function to the compromised patient. Surgical procedures may include use of major flaps, pedicle flaps, microvascular flaps.
		m. General Anesthesia. Administration of ambulatory general anesthesia in the clinic or operating room for completion oral and maxillofacial procedures.
		n. Administration of conscious sedation.

CLINICAL PRIVILEGES *(Continued)*

		o. Other *(Specify)*

LASER PRIVILEGES

Requests for laser privileges may require attendance at a formal laser training program(s), supporting documentation of training, experience, etc., acknowledgement of receipt of the MTF laser policy and procedural guidance, and review and approval by appropriate MTF personnel with oversight responsibilityfor laser therapy. The necessary documentation in support of this request is attached.

Requested	Approved	
		a. Laser Excision/Ablation of intraoral lesions.
		b. Laser Excision/Ablation of maxillofacial cutaneous lesions and facial rhytids.

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*

EVALUATION OF CLINICAL PRIVILEGES - ORAL & MAXILLOFACIAL SURGERY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	PROCEDURE/SKILL	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. Facial Trauma. Diagnosis and treatment of traumatic injuries to the facial hard and soft tissues.			
	b. Pain Control. Diagnosis and treatment of orofacial pain to include therapeutic medications; local anesthesia; intravenous sedation, intramuscular sedation, inhalation sedation, and ambulatory general anesthesia.			
	c. Pathology. Diagnosis and treatment of diseases, neoplasms, infections and other surgical conditions that affect the odontogenic apparatus and other contiguous hard and soft tissue structures.			
	d. Dentoalveolar Surgery. Includes exodontia, alveoloplasty, exostosis removal, vestibuloplasty with soft tissue management of oral defects.			
	e. Maxillofacial Skeletal Deformities. Surgical correction of maxillofacial deformities includes reconstructive procedures that correct deformities of the jaws, facial skeleton, and associated soft tissues. These abnormalities may be caused by genetic, environmental, developmental, functional and/or pathologic aberrations apparent at birth or manifested in subsequent growth and development, or acquired through trauma, neoplastic processes and degenerative diseases. The surgical procedures involve repositioning and recontouring the facial bones to correct functional or pathologic problems. Included are the repair, augmentation, or reconstruction using various osteotomies, autologous bone, cartilage, skin (full and split thickness), fat, allogeneic bone or appropriate alloplastic materials, and primary and secondary nerve graft repairs.			
	f. Temporomandibular Joint. Diagnosis and treatment of conditions involving the temporomandibular joint including neoplasms, infections, degenerative/ dislocation, myofascial and atypical facial pain. This involves open joint and closed joint/arthroscopy procedures and total joint reconstruction.			
	g. Preprosthetic Surgery. Diagnosis and treatment of conditions involving the edentulous or partially edentulous jaw to include use of implantable devices/ materials and augmentation with osseous, skin or mucosal grafts, harvested from donor sites by the Oral and Maxillofacial Surgery Service.			
	h. History and Physical Examination. Physical evaluation of patients treated by the Oral and Maxillofacial Surgery Service with appropriate medical/surgical consultation.			
	i. Diagnostic Procedures. Biopsy and other diagnostic procedures (e.g., laboratory studies, radiographic and arthroscopic) involving lesions or conditions of the facial structures, oral cavity, neck and skin. Included are tomograms, CAT scans, nuclear scans, and contrast studies.			
	j. Salivary Glands. Diagnosis and therapeutic treatment of lesions or conditions of the salivary glands. Surgical treatment of benign lesions involving the major/ minor sublingual and submandibular glands. Malignant neoplasms will be referred to the appropriate oncologic service.			
	k. Maxillofacial Cosmetic Surgery. Cosmetic maxillofacial surgery encompasses those procedures designed to improve form and appearance of the maxillofacial region. Cosmetic surgery is performed on hard and soft tissues to correct maxillofacial adiposity and unattractive deformities of the chin, maxillofacial contour, eyelids, nasal structures, soft tissue of the face and neck, skin surface contour, hair and ear.			

CODE	PROCEDURE/SKILL *(Continued)*	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	l. Reconstructive oral and maxillofacial surgery. The surgical correction of soft and/or hard tissues defects of the jaws, face and contiguous structures, including reduction, revision, augmentation, grafting, and implantation for the correction or replacement of defective structures to assist in restoring function to the compromised patient. Surgical procedures may include use of major flaps, pedicle flaps, microvascular flaps.			
	m. General Anesthesia. Administration of ambulatory general anesthesia in the clinic or operating room for completion of oral and maxillofacial procedures.			
	n. Administration of conscious sedation.			
	o. Other *(Specify)*			
	LASER PRIVILEGES			
	a. Laser Excision/Ablation of intraoral lesions.			
	b. Laser Excision/Ablation of maxillofacial cutaneous lesions and facial rhytids.			

SECTION II - COMMENTS *(Explain any rating that is "Unacceptable".)*

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*