INSTRUCTIONS

All new applicants must meet the following requirements as approved by the UNM SRMC Board of Directors effective: 12/06/2012

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, current clinical activity, and other qualifications, and for resolving any doubts related to qualifications for requested privileges.

Clinical Service Chief: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other requirements:

Note that privileges granted may be exercised only at UNM SRMC and in setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.

This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.
To be eligible to apply for core privileges in Oral and Maxillofacial Surgery, the initial applicant must meet the following criteria:

Successful completion of an ADA accredited Oral and Maxillofacial Surgery advanced training program.

AND

Currently hold certification by the ADA accredited board for your primary specialty or admissible for examination for certification and certification must be achieved within the time frame mandated by the appropriate board or within 3 years after completion of residency training for those specialties where time frames are not mandated. Notwithstanding the foregoing, applicants for clinical privileges may seek an exception to this Board Certification requirement under Section 2.004 of the Bylaws of the Medical Staff of UNM Sandoval Regional Medical Center (the "Medical Staff Bylaws") and may be granted clinical privileges if such applicant is determined, in accordance with Section 2.004 of the Medical Staff Bylaws, to have qualified for one or more of these exceptions.

Required previous experience: Applicants for initial appointment must be able to demonstrate the provision of inpatient, outpatient, or consultative services, reflective of the scope of privileges requested, and demonstrate successful completion of a DDS or DMD or have successful completion of an ADA accredited Oral and Maxillofacial Surgery advanced training program.

Reappointment requirements: To be eligible to renew core privileges in Oral and Maxillofacial Surgery Privileges, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience (inpatient, outpatient, or consultative services) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on the results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.
Privileges include admission, consultation, evaluation, diagnosis and performance of surgical procedures on patients of all ages presenting with illness, injuries, and disorders of both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial regions.

☐ Requested

SPECIAL NONCORE PRIVILEGES (See Specific Criteria)
If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence.

QUALIFICATIONS FOR THE ADMINISTRATION OF SEDATION AND ANALGESIA
(see specific form)
See hospital policy for sedation and analgesia by non-anesthesiologists.

ARTHOSCOPIC SURGICAL PROCEDURES including suturing, triangulation techniques.

☐ Requested

RHINOPLASTY/BLEPHAROPLASY

☐ Requested

HEAD and NECK ONCOLOGY SURGERY – (including extirpative surgical oncology of the head and neck which included but is not limited to endoscopy, maxillectomy, mandibulectomy, composite resection, neck dissection, tracheostomy, transcervical approaches, local and regional flaps, Salivary gland surgery) – Privileges do not include: laryngectomy and microvascular free flap surgery.

☐ Requested
Computer Enhanced Surgical Devise (Robotic Surgery)

☐ Requested

Limited Ultrasound for Guided Procedure (separate form)

CORE PROCEDURES LIST

This list is a sampling of procedures included in the core. It is not intended to be an all-encompassing list, but rather is reflective of the categories/types of procedures included in the core.

To the applicant: If you wish to exclude any procedures, please strike through those you do not wish to request, then initial and date.

Core Procedures Oral and Maxillofacial Surgery

1. Performance of history and physical examinations for patients without underlying conditions
2. Treatment of infections, facial fractures and injuries
3. Correction of jaw deformities
4. Extraction of teeth
5. Alveolectomy
6. Non-arthroscopic temporomandibular joint surgery
7. Diagnostic arthroscopic procedures
Acknowledgement of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at UNM SRMC, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

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Clinical Service Chief’s Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

[ ] Recommend all requested privileges.
[ ] Recommend privileges with the following conditions/modifications:
[ ] Do not recommend the following requested privileges:

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Notes

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Clinical Service Chief Signature ___________________________ DATE ________________