LAKEWOOD REGIONAL MEDICAL CENTER
DEPARTMENT OF SURGERY - Specialty of Otolaryngology

APPLICANT NAME_____________________________________

PLEASE READ BEFORE COMPLETING	
These requirements must be met in order to be eligible for the privileges being requested.	Initial Applicants: (1) Physician shall have satisfied the criteria to be a candidate for the American Board of Otolaryngology or be Certified. (2) Completion of an approved residency in Otolaryngology. Observations/Proctoring: 3 varied, major cases must be observed by an eligible observer. One of the 3 cases observed may be observed by the applicant's associate. Whenever possible, observers must be varied as well. This is a minimum requirement and based upon the review of the cases observed, additional observations may be required. Renewal of Privileges: Major neck procedures: 5/year; Paranasal/sinus surgery: 5/year; Major ear surgery: 2/year.

CORE PROCEDURES: Those considered to be intrinsic to the discipline and are routinely included in any hospital-based post graduate program. Core procedures may be granted in accordance with the above criteria.

Applicant is asked to line through any procedures he/she will not be performing

Core Procedures	Requested	Granted	Denied
	_______	______	_____

Admitting	Excision facial and neck skin lesions
Attending	Major procedures including cure of malignancies
Assisting	Laryngectomy – total; partial
Perform History and Physical	Glossectomy
Tonsillectomy	Mandibulectomy
Adenoidectomy	Mastoidectomy – Simple; Radical
Bronchoscopy	Thyroidectomy
Laryngoscopy	Stapedectomy
Esophagoscopy	Myringotomies and tubes
Nasopharyngoscopy	Rhinoplasty
Submucous resection	Sinus Surgery – Caldwell Luc, Ethmoidectomy, Sphenoidectomy, Frontal
Excision of Benign lesions – neck; Brachial cleft cyst; Thyroglossal Duct cysts	Sinus procedures, endoscopic sinus procedures
Tracheotomy / Tracheostomy	Salivary gland surgery – parotid and submaxillary gland
	Facial Fractures – nasal, maxillary, mandible

SPECIAL PROCEDURES: The following require documentation of additional training:

	Requested	Granted	Denied
Use of Fluoroscopy (copy of current permit must be on file)	______	_____	_____
Moderate Sedation for use outside of OR	______	(see separate credentialing documentation)	
Laser Surgery			
CO2	______	_____	_____
Yag	______	_____	_____
KTP	_____	______	______

I have carefully reviewed this delineation sheet and declare myself competent in all the procedures requested above.

Signature of Applicant:____Date______________

APPROVALS

DEPARTMENT CHAIR____ DATE___________________

MEDICAL EXECUTIVE COMMITTEE__________________________________ DATE___________________

GOVERNING BOARD____ DATE___________________