

Privileges for: Otolaryngology

Request

ST. ELIZABETH - EDGEWOOD  
ST. ELIZABETH - FLORENCE  
ST. ELIZABETH - FT. THOMAS  
ST. ELIZABETH - GRANT CO. (Surgical & other invasive procedures requiring general anesthetic are not offered)

MEC Approval: August 27, 2009, Rev. February 27, 2014

Board Approval: September 14, 2009, Rev. May 5, 2014

DEPARTMENT APPROVAL

\_\_\_\_\_ Approved \_\_\_\_\_ Disapproved

\_\_\_\_\_  
Department/Section Chair Signature Date

MINIMUM REQUIREMENTS

Degree required: MD or DO

Successful completion of ACGME or AOA approved residency training program in otolaryngology-head and neck surgery

Note: For Practitioners (excluding AHPs) who apply for membership after March 2, 2009 be and remain (with a lapse of no longer than one year) board certified in their principal practice specialty, or become and remain (with a lapse of no longer than one year) board certified within six years of completion of their post-graduate medical training. Only those boards recognized by the American Board of Medical Specialties or the American Osteopathic Association are acceptable. This board certification requirement does not apply to applicants who on March 2, 2009 were members in good standing on the medical staff of the St. Luke Hospitals or St. Elizabeth Medical Center.

PRIVILEGES REQUESTED

Pursuant to Bylaws Section 6.1.4, practitioners may exercise the privileges requested and awarded below only at facilities where St. Elizabeth Healthcare offers those services.

I. Core Privileges: Core privileges in otolaryngology include the care, treatment or services listed immediately below. I specifically acknowledge that board certification alone does not necessarily qualify me to perform all core privileges or assure competence in all clinical areas. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below. Please line through and initial any specific privileges within a checked privilege group that you are not requesting.

DESCRIPTION OF CORE PRIVILEGES

Moderate Sedation (requires proof of (a) board certification in Anesthesiology, Cardiology, Critical Care, Pulmonology or Emergency Medicine or (b) current ACLS Certification or (c) satisfactory completion of the ASA Moderate Sedation course).

\_\_\_\_\_  
Anesthesia Section Chair Date

Admit patients; perform histories and physicals; workup, diagnose, and provide nonsurgical and surgical care to patients presenting with illnesses, injuries, and disorders that affect the ears, the respiratory and upper alimentary systems, and related structures of the head and neck. Core privileges also include operative intervention and related preoperative and postoperative care of congenital, inflammatory, endocrine, neoplastic, degenerative, and traumatic states including: temporal bone surgery, paranasal sinus and nasal surgery, maxillofacial surgery including the orbits and facial skeleton, aesthetic, plastic and reconstructive surgery of the face, head, and neck; surgery of the thyroid, parathyroid, pituitary, and salivary glands; head and neck reconstructive surgery relating to the restoration of form and function in congenital anomalies and head and neck trauma and neoplasms; endoscopy, both diagnostic and therapeutic; surgery of the lymphatic tissue of the head and neck.

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**II. Additional Privileges:** In addition to the core privileges requested above, I am requesting the additional privileges below. In addition to meeting the minimum requirements for core privileges, applicants must meet all "Additional Requirements" listed for each privilege below and provide documentation (fellowship completion, training course certification, letter from program director or department chair at primary hospital, etc.) demonstrating appropriate education, training, ability and current competence. Credentialing bodies or persons may request additional documentation or information. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below.

**DESCRIPTION OF ADDITIONAL PRIVILEGES**

\_\_\_\_\_

KTP/YAG

**(ADDITIONAL REQUIREMENT: Proof of Competency)**

\_\_\_\_\_

CO2

**(ADDITIONAL REQUIREMENT: Proof of Competency)**

\_\_\_\_\_

Fluoroscopy

**(ADDITIONAL REQUIREMENT: Radiation Safety certification required. )**

**Applicants Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_