

LIST OF CLINICAL PRIVILEGES – MAXILLOFACIAL PROSTHODONTICS

AUTHORITY: Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.

PRINCIPAL PURPOSE: To define the scope and limits of practice for individual providers. Privileges are based on evaluation of the individual's credentials and performance.

ROUTINE USE: Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from military service.

DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges.

INSTRUCTIONS

APPLICANT: In Part I, enter Code 1, 2, or 4 in each REQUESTED block for every privilege listed. This is to reflect your current capability. Sign and date the form and forward to your Clinical Supervisor.

CLINICAL SUPERVISOR: In Part I, using the facility master privileges list, enter Code 1, 2, 3, or 4 in each VERIFIED block in response to each requested privilege. In Part II, check the appropriate block to either recommend approval, to recommend approval with modification, or to recommend disapproval. Sign, date and forward the form to the Credentials Office.

CODES: 1. Fully competent within defined scope of practice.

2. Supervision required. (Unlicensed/uncertified or lacks current relevant clinical experience.)

3. Not approved due to lack of facility support. (Reference local facility privilege list. Use of this code is reserved for the Credentials Committee/ Function.)

4. Not requested/not approved due to lack of expertise or proficiency, or due to physical disability or limitation.

CHANGES: Any change to a verified/approved privileges list must be made in accordance with Service Specific Credentialing and Privileging Policy.

NAME OF APPLICANT

NAME OF MEDICAL FACILITY

ADDRESS

Dental providers requesting privileges in this specialty must also request privileges in General Dentistry and Prosthodontics

I Scope		Requested	Verified
P387521	The scope of privileges in maxillofacial prosthodontics includes the ability to evaluate, diagnose, consult, manage, and provide therapy and treatment for patients of all ages presenting with acquired, congenital and developmental defects of the head and neck and of methods used to maintain the oral health of patients. Practitioners may assess, stabilize, and determine disposition of these patients.		
Procedures			
Intraoral and extraoral impressions		Requested	Verified
P387523	Ocular impression		
Extraoral maxillofacial prostheses		Requested	Verified
P387529	Facial prostheses (nasal, auricular, orbital, ocular)		
P387531	Cranial prostheses		
P387533	Combination prostheses		
P387537	Custom facemask for burn tissue pressure or athletic mask		
P387539	Commissure splint		
P387543	Other extraoral maxillofacial prosthesis not otherwise defined		
P384974	Earmold fabrication, fitting and modification		
Intraoral maxillofacial prostheses (complex)		Requested	Verified
P387547	Feeding aid obturator		
P387549	Speech aid prosthesis		
P387551	Nasoalveolar Molding prosthesis		
P387553	Palatal augmentation prosthesis		
P387555	Palatal lift prosthesis		
P387557	Radiation prosthesis		
P387559	Radiation shield and other devices		
P387561	Fluoride carriers		
P387563	Surgical (Tissue) stent		

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Procedures (Cont.)			
	Intraoral maxillofacial prostheses (complex) (Con't)	Requested	Verified
P387565	Guide flange prosthesis		
P387567	Mandibular resection prostheses		
P387571	Implants to provide normal symmetry for patients who have incurred trauma, disease or congenital defects		
P387573	Facial augmentation implant prostheses		
P390478	Other intraoral maxillofacial prosthesis not otherwise defined		
	Miscellaneous	Requested	Verified
P387575	Extraoral implants using osseointegrated fixtures		
P387577	Facial implant prostheses and surgical guides		
P390232	Obturator prosthesis		
Other (Facility or provider-specific privileges only):		Requested	Verified
SIGNATURE OF APPLICANT		DATE	

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II CLINICAL SUPERVISOR'S RECOMMENDATION

RECOMMEND APPROVAL

RECOMMEND APPROVAL WITH MODIFICATION
(Specify below)

RECOMMEND DISAPPROVAL
(Specify below)

STATEMENT:

CLINICAL SUPERVISOR SIGNATURE

CLINICAL SUPERVISOR PRINTED NAME OR STAMP

DATE